

***United States Court of Appeals
for the Second Circuit***



APPENDIX

Vol. **III**

77-6152,74

ORIGINAL

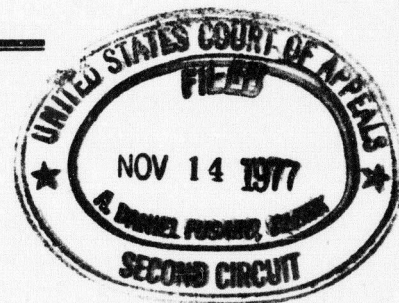
SUPPLEMENTAL JOINT APPENDIX

IN THE

United States Court of Appeals

FOR THE SECOND CIRCUIT

No. 77-6152, 74



BP/S

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf of themselves and all other nonprofit hospitals which are members of the HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., and which are reimbursed for Medicaid Services rendered to hospital patients,

Plaintiffs-Appellants,

—v.—

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, HUGH L. CAREY, as Governor of the State of New York,

Defendants-Appellees,

—and—

F. DAVID MATHEWS, as Secretary of the U. S. Department of Health, Education and Welfare,

Defendant.

**APPEAL FROM THE JUDGMENT OF THE
UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF NEW YORK**

PAGINATION AS IN ORIGINAL COPY

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RELEVANT DOCKET ENTRIES

1977

- May 23 -- Filed transcript of proceedings of March 21, 1977 and April 21, 1977.
- October 4 -- Filed supplement to opinion of Magistrate Jacobs dated June 1, 1977.
- November 11 -- Filed deposition of George Allen.
- November 11 -- Filed stipulation of parties regarding supplemental record of appeal.

1 UNITED STATES DISTRICT COURT
2 SOUTHERN DISTRICT OF NEW YORK

3 -----X
4 HOSPITAL ASSOCIATION OF NEW YORK :
5 STATE, INC., et al,, :
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Plaintiffs,

-vs-

PHILIP BOIA as Commissioner of
Social Services of the State of
New York,

Defendants

76 Civ. 2027

BEFORE: HON. MORRIS E. LASKER,

District Judge

New York, New York

March 21, 1977

9:30 A. M. - Room 1903

APPEARANCES:

JABOB IMBERMAN, ESQ.,

STEVEN S. MILLER, ESQ.,

Attorney for Plaintiffs other than
Health & Hospitals Corp.

PETER F. NADEL, ESQ.,

Attorney for Plaintiff Health & Hospitals Corp.

CHARLES MILLER, ESQ.,

Attorney for Defendants.

JOHN O'CONNOR, ESQ.,

Attorney for Federal Defendant Mathews.

Rec'd 11/9/77
at 5:15 PM
V3

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2 (The following took place in the Judge's Chambers.)

3 THE COURT: The parties have been discussing
4 with the court the order in which future proceedings should
5 be taken up in the light of, first, the remand by the
6 Court of Appeals, and, second, a dispute continuing between
7 the Health & Hospitals Corporation and the State with
8 regard to the correctness of the computation of the payments
9 which have been made or are to be made by the state to the
10 Health & Hospitals Corporation.

11 Mr. Miller has indicated that he believes that
12 the order should be for the court to decide, first, the
13 question of the effect of Congress' repeal of the previous
14 waiver, compelled waiver of immunity by the State and,
15 then, if it is designed unfavorably to the State, proceed
16 to determine whatever other disputes are outstanding,
17 particularly the HHC claim.

18 Mr. Nadel disagrees pointing out that the court
19 had previously heard a similar argument from the State
20 and decided against it.

21 I have just indicated that I think the posture
22 of the case is now different from what it was on the previous
23 occasions when I did decide against the State. I say that
24 for two reasons.

25 First. That on the previous occasion whether the

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2 matter was exclusively in the hands of the Court of Appeals
3 or not there was at least a very serious question as to
4 whether this court had jurisdiction and, in any event, whether
5 it was practicable for this court to decide a matter which,
6 apparently, might be decided by the Court of Appeals.

7 Now, we have been instructed by the Court of
8 Appeals that this court is to decide that question first.

9 Second. On the previous occasion when this
10 issue arose the State had made no payments, as I recall it,
11 to anybody and now, whether or not there is a dispute, at
12 least a substantial amount has been paid to the HHC and the
13 other hospitals, and it seems to me that that, at least,
14 relieves the pressure with regard to the financial pressure
15 of the case and it makes it reasonable to decide the legal
16 question first, especially since if the legal question is
17 decided favorably to the State, it would obviate the financial
18 question altogether.

19 Do you want to make any comment on this point,
20 although you are on the sidelines of the HHC dispute?

21 MR. IMBERMAN: I am on the sidelines as far as
22 that dispute, but I had a comment as to how the 5th amendment
23 and the due process problem should be handled and I think it
24 is so interwoven with everything else.

25 THE COURT: I will hear from Mr. O'Connor -- why

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[4]

2 don't you have your say.

3 MR. IMBERMAN: My feeling, I guess, is somewhere
4 half in between Mr. Miller and Mr. Nadel. I look at this
5 thing as part of the entire litigation package and I look
6 at the fact that we have exactly six weeks in which to get
7 ready for the trial. I spent all of last week in Albany
8 taking depositions of the State Health Department people.
9 I have an entire week of depositions scheduled this week
10 and, of course, one of the deputy commissioners could not
11 be in Albany and I have agreed to take his deposition this
12 evening and then I am going up to Albany to take depositions
13 all of the remainder of this week and I will probably be
14 taking depositions all of next week. I hope by then I will
15 finish.

16 In the meantime, there is a vast amount of other
17 work that has to be done. The State defendants served a
18 very formidable set of interrogatories. We filed objections.
19 They informed us that a Rule 37 motion is being made.
20 We haven't received that paper as yet.

21 That motion will probably be the most important
22 pretrial motion in the case. I will get to that in a minute,
23 your Honor.

24 We are waiting for rulings from the Magistrate
25 on certain matters that are before him.

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[5]

2 THE COURT: Somebody is waiting for rulings from
3 me on an appeal from the Magistrate's rulings to date.

4 MR. IMBERMAN: That's right. Mr. O'Connor has
5 yet to notice his depositions. The State defendants have
6 informed us that they plan to take at least a half a dozen
7 important depositions, but they have withdrawn their notice
8 and I assume that those will come after we answer any inter-
9 rogatories that your Honor says that we have to answer as
10 a result of the Rule 37 motion.

11 I am sure I have left out a couple of things,
12 but there is an awful lot of work to be done in addition
13 to preparing witnesses for trial, writing trial briefs and
14 everything else to get ready for May 2 and I consider your
15 Honor's May 2 trial date an absolute.

16 In view of all of that, I would like to suggest
17 that your Honor take briefs from us on the 5th Amendment
18 matter, along with the trial briefs and everything else,
19 and that everything be decided at once.

20 I think it will be almost impossible for us to
21 put aside other things and focus on writing an important
22 constitutional brief within the six weeks that we have to
23 and do all the pretrial work and prepare for trial.

24 THE COURT: That rather assumes, I take it,
25 that the Court would not make any decision on the pending

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2 dispute, which I have just described, between HHC and the
3 State until it did decide or concurrently with a decision
4 of the constitutional question.

5 MR. IMBERMAN: We will have the trial in any
6 event. We have the action under the state so it seems to
7 me in view of the enormous amount of work that has to be
8 done in the next six weeks, after all this is an important
9 case, we have to prepare it properly, it seems to me --

10 THE COURT: I am not disagreeing with you. I
11 am thinking through what you are saying and trying to under-
12 stand what the consequences of it would be.

13 Mr. Nadel.

14 MR. NADEL: I would just like to add, your
15 Honor, that on behalf of the Hospitals Corporation, we
16 view the decision concerning the recomputation of utmost
17 priority.

18 THE COURT: Would you remind me how much is
19 involved, how much the State agrees you are entitled to?

20 MR. NADEL: The State agrees that we are entitled
21 to \$44,000.

22 THE COURT: Thousand?

23 MR. NADEL: \$44,000. I thought your Honor asked
24 the range of difference between us.

25 THE COURT: I am asking how much is involved

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2 in the dispute between you under this method of computation?

3 MR. NADEL: I would say approximately \$45,000,000
4 and that is a number that figures significantly in the
5 budget that the Corporation is required to submit to the
6 EFCB and for planning and those are matters of great
7 immediacy.

8 MR. IMBERMAN: I do want to say one thing about
9 that dispute between the Health Department and the HHC.
10 Based on the affidavit, which we got along with a letter
11 from Mr. Miller, we could not understand how they were going
12 to recalculate and recompute these rights and there was a
13 possibility that by changing the groupings of the hospitals
14 that there was going to be some effect on the other voluntary
15 hospitals because we didn't know how they were going to do
16 it or what that effect would be, I wrote to Mr. Miller
17 saying that I reserved our right to object to their method.
18 I wasn't getting involved in the amount of money, but it is
19 the method that might have an adverse impact on the voluntary
20 hospitals and that I reserved my rights and that is primarily
21 my major interest here.

22 THE COURT: Mr. Miller, do you want to comment
23 on Mr. Imberman's suggestion?

24 MR. MILLER: Yes, your Honor.

25 You have a trial at 10 o'clock?

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[8]

2 THE COURT: I do, but I am going to be late.

3 MR. MILLER: Your Honor, I don't want to get into
4 a lot of subjects which Mr. Imberman touched on, but I do
5 have two pieces of correspondence, one letter and one
6 response to a pleading which I have brought with me, and I
7 am going to make hand delivery on your Honor and on the
8 parties.

9 One of those I have asked your Honor if you
10 could schedule a conference to discuss the procedure looking
11 toward a trial of this case.

12 I will say this on the narrow question before
13 us: I don't see why, we are all busy, but the demands that
14 have been made on the State defendants in this case have been
15 quite enormous. We think that this particular issue ought
16 to be decided now for this reason:

17 At the moment the State of New York has paid out
18 about \$50,000,000 in funds pursuant to your order, but there
19 is a substantial question on that. Part of that will be
20 reimbursed by the Federal Government but the rest of it will
21 not be. That amount of money figures quite heavily in the
22 calculations of the State as to its coming budget and to its
23 fiscal soundness.

24 This is precisely the kind of question that we
25 dealt with by the Court of Appeals in the Rothstein case,

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2 orders of the court that affect State budgetary process.
3 This is a considerable sum of money and it is precisely
4 issue of policy that underlines the legal question that is
5 before your Honor.

6 It is a matter that has been briefed before two
7 courts and kicked around a little bit here. I do think the
8 State is entitled to a response on this matter at the earl
9 possible time.

10 THE COURT: Mr. O'Connor.

11 MR. O'CONNOR: Your Honor, we are on the side-
12 lines with regard to the IMHC dispute. We are also on the
13 sidelines with regard to the effect of the repeal of the
14 statute in the Court of Appeals. We are examining the
15 remand to see if the question the Court of Appeals raised
16 with regard due process, et cetera involves us in a way that
17 we --

18 THE COURT: You will be involved financially
19 anyway in the light of what Mr. Miller has said, if the
20 ruling is against you or either way.

21 MR. O'CONNOR: That is true, yes. We are
22 involved financially, but we were involved financially when
23 it went before the Second Circuit and my client took no
24 position at that time, but we are examining the remand order
25 to see if, for example, there is a constitutional question,

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[10]

2 if that would involve us.

3 Having said that, I don't have anything to add
4 to the scheduling of matters, your Honor.

5 THE COURT: Gentlemen --

6 MR. IMBERMAN: May I just say one word about what
7 Mr. Miller said? Mr. Miller's emphasis on the money involved
8 here seems to operate on the assumption that if the court
9 rules on the 11th Amendment problem, that is going to mean
10 a ruling on the merits, and that is not so.

11 THE COURT: I don't think he said that at all.

12 MR. IMBERMAN: What he is talking about is as
13 if the State defendants were to win on the 11th Amendment,
14 that that would mean that the State of New York would not
15 owe the hospitals any money. That isn't so because, as far
16 as the merits of the case are concerned so far, I mean,
17 we haven't lost anything here, and what has been paid under
18 the \$50,000,000 has been paid because your Honor ruled that
19 the State had no right to implement the new regulations
20 before HEW approval of them is concerned.

21 I have no doubt that your Honor is correct on
22 that. I have no doubt that the Court of Appeals will affirm
23 on that when it gets there so that the State owes this
24 money.

25 The only question is going to be whether we are

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[11]

2 entitled to a judgment in the Federal Court or that we are
3 entitled to a judgment in the State Court. I have some
4 real doubts, if we were to win on the merits, but lose on
5 the technicality that we are not entitled to a judgment in
6 this court, that the State of New York is going to say,
7 hospitals are going to take the money away from you, even
8 though as far as the merits are concerned we are entitled
9 to them, so I don't think you should look at this as a way
10 of helping the State solve its budgetary problems.

11 They owe the money, there's no question of it,
12 whether State law or Federal

13 THE COURT: That may or may not be true. I don't
14 know what will happen outside this court. I think I have an
15 obligation to deal with my own affairs.

16 It does not seem to me, much as I understand the
17 burdens on all of us and I include myself on that, that it
18 will add significantly to the burdens on all of us for me
19 to ask all of you, as I now do, to brief the one issue that
20 has not been briefed on the 11th Amendment matter, that is
21 the due process issue, so that I can decide it as promptly
22 as possible.

23 It seems to me the logical and sensible way that
24 this would ordinarily be done, and I feel more strongly
25 about it now that the significant payments have been made

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[12]

2 and it can't be said that the situation is as critical at
3 least for the hospitals as it was before, but the shoe is
4 now pinching on the other foot, I suppose.

5 So, today is the 21st. It is a question of how
6 soon you can do it. 10 days?

7 MR. IMBERMAN: They are the moving party, your
8 Honor. Shouldn't we get the brief from them and then reply?

9 THE COURT: Yes, I suppose so. Let me ask you
10 to put in your brief and I will give them an opportunity to
11 reply briefly to the plaintiffs', if you feel that is
12 necessary.

13 What would you suggest, Mr. Miller, as the first
14 State?

15 MR. MILLER: Your Honor, 10 days sounds good to
16 me.

17 THE COURT: All right. I would ask counsel on
18 the other side to answer within a week. I think we all
19 really know what the general outline of the issue is and
20 then let's say three days after that, Mr. Miller, three
21 business days for you to put in any further comment you
22 have.

23 Now, can we get for a moment then to the question
24 of the IUIC motion, which you said, Mr. Nadel, at first you
25 thought that a master might be useful but you since, I

AN OVERVIEW OF
NEW YORK STATE TITLE XIX PLAN

When the Department of Health, Education, and Welfare must evaluate numerous proposals for substantive revisions to the New York State Title XIX Plan, it does not seem appropriate to consider them only singly and in the abstract. They ought to be examined in consideration of their interaction with the rest of the State Plan as presently applied and with the philosophy of prospective reasonable cost reimbursement.

We have discussed the severe and adverse impacts of the specific proposed amendments in Transmittal Numbers 77-7 and 77-10. Their impact becomes even greater when considered in light of rigid enforcement, denial of waivers of the 60-70-80% occupancy sanctions, use of questionable grouping criteria, imposition of limitations on applicable costs not consistent with Medicare proposals and other similar changes.

The inescapable conclusion to be drawn is that the overall impact of the New York State Title XIX Plan as it exists along with the proposed amendments is so substantially different from that originally approved as an alternate plan by the Secretary in September 1971 that de novo consideration should be given to whether it complies with the reasonable cost requirements and other approval criteria under Medicaid law and regulations.

The State Plan originated as a new prospective reimbursement system which our Association worked hard to cooperate with. That system provided for a liberal system for the correction of unintended and unanticipated damage. It was established in a climate of flexibility and cooperation. It contained incentives for efficient production and encouraged efforts toward improvements in the quality of hospital services. Unfortunately, it has deteriorated into a rigid system which provides few, if any, possibilities for relief, is without incentives, and inevitably requires a continual reduction in the level of hospital services among the best institutions in the system.

We urge that, in addition to a review of the specific amendments now under scrutiny, the Secretary should again conduct a most thorough review of the overall appropriateness of New York State's alternate method as now proposed and implemented to determine whether it still complies with the letter and the spirit of the Medicaid statutes and regulations.

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[20]

2 But the significance of this is that the issue
3 of this particular provision has been given quite thorough
4 consideration once again both by the state and by HEW in
5 the approval process.

6 So that to the extent the process issues are at
7 stake, the process in 1976 is now not by any means the whole
8 or even the main record.

9 In order now to test the validity of the process
10 of , the residents and interne provision, I think
11 one would need to consider not only the 1976 record but also
12 the 1977 record, where the issue once again considered by
13 HEW.

14 THE COURT: That might be true if ultimately
15 the courts rule in your favor on the effect of the Eleventh
16 Amendment repealer. But just so we understand each other,
17 if the courts were to hold that in spite of the repealer
18 statute the waiver was good, the state's waiver was good
19 for that period, then we would still be faced with the '76
20 question, would we not?

21 MR. C. MILLER: That's correct, if the court
22 so ruled.

23 THE COURT: I'm not suggesting a ruling.

24 MR. IMBERMAN: Wouldn't the issue be what they
25 did and the record before them in '76 and not what they

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[21]

2 might have done a year later?

3 THE COURT: Well, it certainly would be, if
4 you were entitled to any money back, if they had done some-
5 thing wrong. If as a result of the repealer statute the
6 courts were to rule that you just couldn't get a money
7 judgment, then it seems to me that Mr. Miller's position
8 might make some sense, that you look at the processes up to
9 date and see what happened. I'm not ruling that way.

10 MR. IMBERMAN: In any event, the changes that
11 have been made have a significant bearing on the case.

12 THE COURT: Yes, I can see that, that they
13 might anyway. But I didn't understand what your reference
14 was to the ceiling situation.

15 MR. MILLER: As to the ceilings, the regulations
16 retain the concept of ceilings.

17 THE COURT: Yes. But at what level?

18 MR. C. MILLER: The hundred per cent ceilings.
19 The level of the ceilings aren't changed. The groupings
20 of the hospitals has been totally rewritten.

21 THE COURT: Okay. Now, do you want to go on?

22 MR. C. MILLER: Yes. So it seems to me --
23 the first point was that the 1976 regulations by themselves,
24 to the extent changed, are relevant only if there is a right
25 to retroactive relief, as you said.

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[22]

2 To determine whether that is going to be part
3 of this case or not seems to me --

4 THE COURT: It obviously points up the necessity
5 of deciding that as rapidly as possible. All the papers
6 are in now, are they not?

7 MR. C. MILLER: All the papers are in, yes.

8 On the question of future relief, to the extent
9 that there are challenges to ceilings and to the other
10 changes that have been made in the 1977 regulations, if
11 plaintiffs want to challenge them, and I don't know if they
12 do yet, it seems to me that the record we have made so far
13 is nto complete and you have to try that issue, because if
14 the challenge is to the process of the regulations for
15 adoption of the regulations now in effect, that process
16 is one that took place in 1977.

17 THE COURT: I suppose a comment from plaintiffs'
18 counsel as to how they feel a change in the regulations
19 affects what they intend to do about it. I don't know
20 if you have had a chance to study them.

21 MR. IMBERMAN: Your Honor, all I can say is
22 that it was my understanding that there were certain changes
23 made in 1977 and that by far the largest part of Part 86,
24 which was in effect in 1976, remain in effect in 1976.

25 THE COURT: In '77.

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[23]

2 MR. IMBERMAN: Some of the most important aspects
3 of the things were challenged here, such as the ceilings
4 of the group average, the internes and residents' disallow-
5 ance of costs, the change in Section 86.21(k), and some
6 other things have been changed.

7 I can't speak at this moment, and I don't think
8 I am authorized to speak for my client, as to what the
9 hospitals intend to do. As Mr. Miller has said, whatever
10 regulations they have promulgated now have to be changed
11 to meet certain conditions which HEW said it will insist
12 on.

13 Until we see the regulation in final form,
14 until my client makes a determination, I don't see how I
15 can say anything. But I don't think that whatever changes
16 the state made in 1977 should affect ordelay this case.

17 MR. C. MILLER: Your Honor, one point that I
18 was suggesting for my comments was that it is important
19 to have the jurisdictional question decided because --

20 THE COURT: I don't see that anybody can differ
21 on that.

22 MR. C. MILLER: On the question of the trial
23 going forward on May 2, we have, like Mr. Imberman, been
24 puzzled as to how the case could be divided so that a mean-
25 ingful piece of it could be tried on --

COVINGTON & BURLING
888 SIXTEENTH STREET, N. W.

WASHINGTON, D.C. 20006

TELEPHONE (202) 452-6000

WRITER'S DIRECT DIAL NUMBER

452-6290

May 2, 1977

NEWELL W. ELLISON
JOHN G. LAYLIN
H. THOMAS AUSTERN
FONTAINE C. BRADLEY
EDWARD BURLING, JR.
J. HARRY COVINGTON
COUNSEL

JOHN SHERMAN COOPER
EDWIN S. COHEN
OF COUNSEL

TW: 710 822-0008
TELE: 88-583
CABLE: COVING

HOWARD C. WESTWOOD
JOHN T. SAPIENZA
JAMES H. MCGLOTHLIN
ERNEST W. JENNES
STANLEY L. TENHO
JAMES C. MURRAY
JOHN A. DOUGLAS
WILTON CAROTHERS
J. RANDOLPH WILSON
ROBERTS D. OWEN
EDGAR F. CZARHA, JR.
WILLIAM H. ALLEN
DAVID B. ISBELL
JOHN B. JONES, JR.
H. EDWARD DUNKELBERGER, JR.
BRUCE MCADOO CLAGETT
JOHN S. KOCH
PETER BARTON HUTT
HERBERT OTH
CYRIL V. SMITH, JR.
HARRA A. WEISS
HARRIS WEINSTEIN
JOHN B. DENNISTON
PETER J. NICHOLS
MICHAEL DOUDIN
BINGHAM D. LEVERICH
ALLAN J. TOPOL
VIRGINIA O. WATKIN
RICHARD O. COPAREN
CHARLES LISTER
PETER D. TROOSOFF
WESLEY S. WILLIAMS, JR.
DONIS D. BLAZEK
WILLIAM D. IVERSON

CHARLES A. HORSKY
W. CROSSBY ROPER, JR.
DANIEL M. GRIBBON
HARRY L. SHNIDERMAN
DON V. HARRIS, JR.
WILLIAM STANLEY, JR.
WEAVER W. DUNNAN
EDWIN M. ZIMMERMAN
JEROME ACKERMAN
HENRY P. SAILER
JOHN H. SCHAFER
ALFRED H. MOSES
JOHN LEMOYNE ELLCOTT
PAUL R. DUKE
PHILIP R. STANSBURY
CHARLES A. MILLER
RICHARD A. BRADY
ROBERT E. O'MALLEY
EUGENE I. LAMBERT
JOHN VANDERSTAR
NEWMANT T. HALVORSON, JR.
HARVEY M. APPLEBAUM
MICHAEL S. HORNE
JONATHAN D. BLAKE
CHARLES E. BUFFON
ROBERT N. SAYLER
E. EDWARD BRUCE
DAVID N. BROWN
PAUL J. TAGLIABUE
ANDREW W. SINGER
DAVID H. HICKMAN
RUSSELL H. CARPENTER, JR.
NICHOLAS W. FELS
THEODORE L. GARRETT

The Honorable Morris E. Lasker
United States District Court
Southern District of New York
United States Courthouse
Foley Square
New York, New York 10007

Re: Hospital Association of New York
State, Inc., et al. v. Toia, et al.
76 Civ. 2027 (MEL)

Dear Judge Lasker:

On April 14, 1977, I wrote to advise you of the approval of HEW on March 31, 1977, of certain changes in the New York State methodology for reimbursing hospitals for their services under the Medicaid program. As the letter indicated, HEW's approval was subject to certain conditions to be satisfied by May 1, 1977.

My purpose in writing now is to inform the Court that the conditions of HEW's approval have been satisfied. This is reflected in the enclosed letter from Mr. Toby, the Regional Commissioner of the Department of Health, Education and Welfare, to Mr. Toia.

Some additional explanation is appropriate with respect to the first of the conditions set forth in HEW's approval letter of March 31, 1977. One of the changes is the addition to section 86-1.14(b) of a provision limiting allowable routine in-patient costs to those incurred in providing services for days that do not exceed the weighted average length of stay of all hospitals in a group developed for the purpose of this length-of-stay provision. The limitation is based on

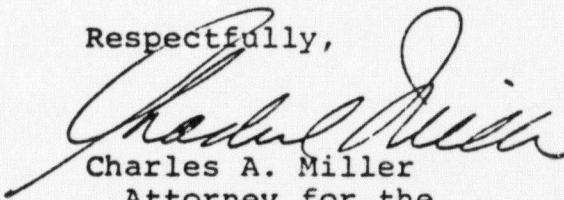
The Honorable Morris E. Lasker
May 2, 1977
Page Two

length-of-stay data for the base period, but the disallowance for excessive length of stay in the base period can be avoided by a hospital that reduces length of stay in the payment year to the base period group average or lower.

The State had further provided that the disallowance under this provision would be limited to costs attributable to a maximum of two days of excessive length of stay. HEW's original letter of approval imposed the condition that this two-day maximum be removed. This would have made the financial impact on the hospitals of the length-of-stay provision far more onerous. The State felt that a more limited disallowance would be more consistent with the aims of the regulation and the needs of the hospitals, and it has pursued this subject further with HEW, as a result of which HEW has agreed to withdraw this condition to its approval. Accordingly, the approved plan includes the two-day maximum on the length-of-stay disallowance.

The State is continuing to study the issue of a limit on the length-of-stay disallowance, and it may at some future time adjust the two-day maximum or substitute a different form of limitation. We will keep the Court advised in the event of any changes in the state plan on this subject.

Respectfully,


Charles A. Miller
Attorney for the
State Defendants

mb
Enclosures

cc (w/encls.): Jacob Imberman, Esq.
Peter F. Nadel, Esq.
John M. O'Connor, Esq.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

SOCIAL AND REHABILITATION
SERVICE

April 29, 1977

Mr. Philip L. Toia
Commissioner
State Department of Social Services
Ten Eyck Office Building
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Toia:

This will acknowledge receipt of your letter of April 28, 1977 transmitting submittal 77-7 (revised) relating to the reimbursement methodology for inpatient hospital services.

We find that the revision to 86-1.17(7) which permits appeals to the length of stay ceiling for reasons other than reduced length of stay, and also permits an institution to appeal its placement in a particular group, satisfies condition number 3 in my letter of 3/31/77.

We also find that the revision to 86-1.26 which deletes the words "and supervising physicians", and your statement in your letter of 4/28/77, that this provision will continue to be implemented as previously approved, satisfies condition number 2 in my letter of 3/31/77.

Further, because of the continuing discussions between the State and HEW, condition number 1 has been eliminated and no revision is required to the provisions of 86-1.14(b)(2).

Therefore, having met all the conditions, as we requested by May 1, 1977, submittal 77-7(revised) is thereby approved for incorporation into the Title XIX State plan.

Sincerely,

William Tobey
William Tobey
Regional Commissioner

7-77 7-1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State New York

Methods and Standards for Establishing Payment Rates -

Inpatient Hospital Care

Part 86

TITLE XIX PLAN

35-1577 7 1

Section		Section	
86-1.1	Definition	86-1.18	Rates for services
86-1.2	Medical facility rates; article IX-C Corporations	86-1.19	Rates for medical facilities without adequate cost experience
86-1.3	Financial and statistical data required	86-1.20	Less expensive alternatives
86-1.4	Uniform system of accounting and reporting	86-1.21	Allowable costs
86-1.5	Generally accepted accounting principles	86-1.22	Recoveries of expense
86-1.6	Accountant's certification	86-1.23	Depreciation
86-1.7	Certification by operator or officer	86-1.24	Interest
86-1.8	Audits	86-1.25	Research
86-1.9	Patient days	86-1.26	Education activities
86-1.10	Effective period of reimbursement rates	86-1.27	Compensation of operators and relatives of operators
86-1.11	Computation of basic rate	86-1.28	Costs of related organizations
86-1.12	Payment for referred ambulatory services	86-1.29	Return on investment
86-1.13	Groupings	86-1.30	Capital cost reimbursement
86-1.14	Ceilings on payments	86-1.31	Termination of service
86-1.15	Adjustments to basic computed rate	86-1.32	Sales, leases and realty transactions
86-1.16	Final rates	86-1.33	Reserved
86-1.17	Revisions in certified rates	86-1.34	Interim Rules for Residential Health Care Facilities

Section 86-1.1 Definition. As used in this Part, the term "medical facility" shall be deemed to include all facilities or organizations covered by the term "hospital or home health agencies" as defined in article 28 of Public Health Law, except residential health care

facilities provided that such medical facility possesses a valid operating certificate issued by the State Commissioner of Health and where required, has been established by the Public Health Council.

86-1.2 Medical facility rates; Article IX-C Corporations. (a) Computation of rates of payment by Article IX-C Corporations to medical facilities shall be governed by the provisions of this Part.

(b) Each such corporation shall submit, prior to the effective date no later than ninety (90) days of rates of payment (unless otherwise specified by the State Commissioner of Health), for approval by the State Commissioner of Health, a proposed reimbursement formula not inconsistent with the rules set forth in this Subpart.

(c) Any such corporation or combination of corporations may, upon application to and approval of the State Commissioner of Health, use a different grouping of facilities for reimbursement computation purposes, provided such grouping assures incentive for the efficient operation of individual medical facilities equal to those under the groupings provided for in section 86.13 of this Part.

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_____ (d) The projection factors to be used by Article IX-C Corporations and the State Department of Health in inflating the historical costs in the base year to anticipated costs for the rate period will be those developed by the State Department of Health in conjunction with Article IX-C Corporations with such other advice and consultation as deemed appropriate by the Commissioner of Health.

(e) The State Commissioner of Health may not certify rate schedules for payments by such corporations unless they have submitted to the Commissioner and received approval of a plan which:

1. establishes a procedure for monitoring the need for hospital admissions of its subscribers; and
2. establishes a procedure for the re-certification of a subscriber's continued hospital service needs.

complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Medical facilities certified for title XVIII (medicare) shall use the same fiscal year for Title XIX (medicaid) and title V (children's bureau programs) as is used for title XVIII. All medical facilities must report their operations from January 1, 1977 forward on a calendar year basis.

(b) Financial and statistical reports required by this Part shall be submitted to the department and/or its agent no later than 120 days following the close of the fiscal period. Extensions of time for filing reports may be granted upon application received at least 15 days prior to the due date of the report and only in those circumstances where the medical facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a medical facility fails to file the required financial and statistical report on or before the due date, or as the same may be extended pursuant to paragraph (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rate is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the department a

correction of such information or data which meets the same certification requirements as the document being corrected.

86-1.4 Uniform system of accounting and reporting. Medical facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by the various types of medical facilities in accordance with the appropriate section of the State Hospital Code covering the particular type of facility. Rate schedules shall not be certified by the Commissioner of Health unless medical facilities are in full compliance with reporting requirements of these sections.

86-1.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility unless the reporting instructions authorize specific variation in such principles.

~~86.6 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to medical facilities operated by units of government of the State of New York.~~

86-1.6 Accountant's certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish.

(b) The requirements of subdivision (a) of this section shall apply to medical facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section. Certification of reports from these facilities will be required effective with report periods

86-1.7 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

86-1.8 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed at which time such rate or adjusted rate will be construed to represent the final rate.

(b) Subsequent to the filing of fiscal and statistical reports, field audits shall be conducted of the records of medical facilities, when appropriate, and in a time and manner to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (Medicare - Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.

(c) (The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department.) Audits must be completed within six (6) years from the due date of the report or the date of their filing with the department, whichever is later. This limitation shall not apply to situations in which fraud may be involved.

~~(d) Medical facilities shall be given 30 days after the mailing of notification of audit findings to appeal such findings by submitting data intended to justify the facility's position in the areas of disagreement. Failure by the medical facility to reply to such findings within the 30 day period, or to receive from the department an extension of time for reply, shall be considered as acceptance of the findings.~~

~~(e) Rate revisions resulting from audit findings may be made retroactively to the period or periods during which the rates based on the periods audited were established.~~

~~(f) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion of negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.~~

(d) Upon completion of the audit the medical facility shall be notified of the time and place of a closing conference. The medical facility may appear in person or by any one authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall thereafter be provided with the final audit report, the rate computation sheet and the rate, which shall be final unless within 30 days of receipt of the final audit report, the medical facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and forwarding all material documentation in support of the medical facility's position.

(1) The division upon receipt of such request, shall assign such report to a staff person who shall review the audit report with the medical facility and shall reduce to writing the substance of any agreement reached and any unresolved items, setting forth the position of the medical facility and the Department on such unresolved issues.

(2) Every effort shall be made to resolve any disagreement at the bureau review and if resolution is not reached to reduce to writing a statement of the facts and issues.

(3) Any adjustments to the audit report, statement of agreement or statement of position as the result of the bureau review shall be final unless, within 30 days of the receipt thereof, the medical facility initiates a review by the rate review panel by notifying the Division of Health Care Financing by registered or certified mail that such review is requested. The medical facility shall submit with such notification all documentation deemed by the medical facility to be relevant to such review and in the absence of agreement as to facts shall set forth in clear and concise terms each and every error which the medical facility alleges has been made together with a statement of the fact or law upon which the medical facility relies.

(f) The rate review panel shall consist of a deputy commissioner and two independent consultants. It shall review all material presented to it with the assistance of department staff and shall make its recommendations to the commissioner. The panel shall meet at such time and place as designated by the first deputy commissioner.

(g) The commissioner shall, upon receipt of the recommendation of the rate review panel, make a determination of the controverted items of the final audit report and the rate as adjusted in accordance with such determination, which rate shall be final except that for those determinations which present a factual issue, as determined by the commissioner, the medical facility may initiate a hearing to refute those items of the audit report adverse to the interests of the medical

facility by serving on the commissioner by certified or registered mail a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report together with copies of any documentation relied on by the medical facility in support of its position.

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- (1) Upon receipt of such notice the commissioner shall:
 - (i) designate a hearing officer to hear and recommend;
 - (ii) establish a time and place for such hearing;
 - (iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto.

The issues and documentation presented at such hearing shall be limited to the factual issues and documentation presented to the rate review panel.

- (2) The final audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.

- (3) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and the State Administrative Procedure Act, which section 12-a reads as follows:

- " § 12-a. Formal hearings; notice and procedure
1. The commissioner, or any person designated by him for this purpose, may issue subpoenas and administer oaths in connection with any hearing or investigation under or pursuant to this chapter, and it shall be the duty of the commissioner and any persons designated by him for such purpose to issue subpoenas at the request of and upon behalf of the respondent.
 2. The commissioner and those designated by him shall not be bound by the laws of evidence in the conduct of hearing proceedings, but the determination shall be founded upon sufficient legal evidence to sustain it.

prior to the date of the hearing, provided that, whenever there is of danger to the public health it appears prejudicial to the interests of the people of the state to delay action for fifteen days, the commissioner may serve the respondent with an order requiring certain action or the cessation of certain activities immediately or within a specified period of less than fifteen days and the commissioner shall provide an opportunity to be heard within fifteen days after the date the order is served.

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4. Service of notice of hearing or order shall be made by personal service or by registered or certified mail. Where service, whether by personal service or by registered or certified mail, is made upon an infant, incompetent, partnership, corporation, governmental subdivision, board or commission, it shall be made upon the person or persons designated to receive personal service by article three of the civil practice law and rules.¹

5. The attorney-general may prefer charges, attend hearings, present the facts, and take any and all proceedings in connection therewith.

6. At a hearing, the respondent may appear personally, shall have the right of counsel, and may cross-examine witnesses against him and produce evidence and witnesses in his behalf.

7. Following a hearing, the commissioner may make appropriate determinations and issue an order in accordance therewith.

8. The commissioner may adopt, amend and repeal administrative rules and regulations governing the procedures to be followed with respect to hearings, such rules to be consistent with the policy and purpose of this chapter and the effective and fair enforcement of its provisions.

9. The provisions of this section shall be applicable to all hearings held pursuant to this chapter, except where other provisions of this chapter applicable thereto are inconsistent therewith, in which event such other provisions shall apply."

(h) Rate revisions resulting from the procedure set forth in this section may be made retroactive to the period or periods during which the rates based on the periods audited were established.

(i) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent

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S revisions.

60-1.7 Patient days. (a) A patient day is the unit of measurement for lodging provided and services rendered to one inpatient between the census-taking hour on two successive days.

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(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother's discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

~~(d) For reimbursement purposes, maternity patient days, pediatric patient days and medical-surgical patient days shall be determined by using the higher of minimum utilization factors of 60 percent, 70 percent and 80 percent, respectively, of certified beds or the actual patient days, of care as furnished by the facility. Maternity service patient days, for the purposes of this computation, shall include total inpatient service days for all patients housed in the maternity unit. This subdivision shall become effective for minimum utilization for maternity unit services on January 1, 1973 and for pediatric and medical services with the rates established based on fiscal data submitted by hospitals for fiscal periods ending in 1972. The provisions of this subdivision may be waived by the State Commissioner of Health, upon application by the health facility for decertification of beds, for seasonal utilization variations, or for similar reasons, in those cases where waiver is found to be a matter of public interest and necessity.~~

(d) For reimbursement purposes, patient days for Medical-surgical, Pediatrics, and Maternity shall be computed as follows:

(1) Medical-surgical patient days for facilities located in counties having an average population density of 100 or more persons per square mile shall

be determined by using the higher of the minimum utilization factor of 85% of certified beds or actual patient days of care furnished by the facility. Medical-surgical patient days for facilities located in counties having an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 80% of certified beds or actual patient days of care furnished by the facility.

(2) Pediatric patient days shall be determined by using the higher of the minimum utilization factor of 70% of certified beds or actual patient days of care furnished by the facility.

(3) Maternity patient days for facilities located in areas not having a plan approved by the Commissioner for the regionalization of obstetrical services shall be determined by using the higher of the minimum utilization factor of 60% of certified beds or actual patient days of care furnished by the facility. Maternity service patient days shall include total inpatient service days for all patients housed in the Maternity unit. Maternity patient days for facilities located in areas having a plan approved by the Commissioner for the regionalization of obstetrical service, and subsequent to January 1, 1978 for all facilities including those services in areas not having an approved plan shall be determined as follows:

- (i) Maternity patient days for facilities in counties with an average population density of 100 or more persons per square mile shall be determined by using the higher of the minimum utilization factor of 75 per cent of certified beds or, if the facility generated less than 1,500 live births, the difference between 1,500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or, if the facility generated more than 1,500 live births, the actual days of care furnished by the facility.

(ii) Maternity patient days for facilities in counties with an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 60 per cent of certified beds or, if the facility generated less than 500 live births, the difference between 500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or, if the facility generated more than 500 live births, the actual days of care furnished by the facility.

(iii) Maternity service patients for purpose of computation of (i) and (ii) above shall include only obstetrical patients housed in the maternity unit. All other patients housed in the maternity unit shall, for reimbursement purpose, be considered medical-surgical patient days.

(4) Provisions (1) and (2) of this subdivision may be waived in all or part by the Commissioner of Health in those cases where waiver has been demonstrated to be a matter of public interest and necessity. Provision (3) may be waived in those cases wherein there is an approved regional plan and wherein the service in question, its capacity and operation are consistent with the approved regional plan.

(e) For reimbursement purposes patient days for open heart surgery, coronary angiography and other cardiac invasive procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations or procedures and carrying out fewer than 100, 200 or 25 operations or procedures, respectively, during the reporting period.

(1) Patient days for any facility engaged in open heart surgery and carrying out less than 100 such operations during the reporting period shall be increased by an amount equal to the average length of stay for open heart surgery cases multiplied by the difference between 100 and the actual open heart surgery operations carried out by the facility.

(2) Patient days for any facility engaged in coronary angiography and other cardiac invasive procedures and carrying out less than 200 such procedures during the reporting period shall be increased by an amount equal to the average length of stay for such procedures multiplied by the difference between 200 and the actual procedures carried out by the facility.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants during a reporting period shall be increased by an amount equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity.

86-1.10 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies shall be for a 12-month calendar year period or for such other period as may be prescribed. Certification or reimbursement rates by Article IX-C Corporations shall be for the periods specified in the reimbursement formula approved by the Commissioner of Health.

86-1.11 Computation of basic rate. (a) Basic rates shall be computed on the basis of allowable fiscal and statistical data submitted by the medical facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

(b) Reimbursement rates for emergency and clinic outpatient services shall be computed on the basis of allowable costs for such services and the units of service.

(1) Units of service for facilities providing radiotherapeutic services and carrying out less than 6000 procedures during the reporting period shall be increased by the difference between the number of procedures carried out and 6000.

(2) Units of service for facilities providing renal dialysis services and carrying out less than 1200 procedures if a hospital unit or 3000 procedures if a free standing chronic renal dialysis treatment center shall be increased by the difference between the number of procedures carried out and either 1200 or 3000 depending on the type of facility.

(3) The provisions of paragraphs (1) and (2) of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity.

86-1.12 Payment for referred ambulatory services. Effective July 1, 1970, payments to hospitals for services to referred ambulatory patients shall be on a fee-for-service basis in accordance with State fee schedules promulgated for the appropriate services.

86-1.13 Groupings. ~~(a) For the purpose of establishing ceilings, medical facilities shall be grouped as follows:~~

~~(1) Type of medical facility.~~

~~(i) hospitals part of or affiliated with teaching centers of maintaining a substantial program of graduate education by number and size of American Medical Association and American Dental Association approved residency programs, adjusted by wage geographic differentials;~~

~~(ii) general hospitals;~~

~~(iii) special hospitals by type;~~

~~(iv) independent out-of-hospital health facilities;~~

~~(v) home health agencies.~~

~~(2) Geographic areas for non-teaching hospitals.~~

~~(i) New York City area;~~

~~(ii) New York suburban area (Nassau, Suffolk, Rockland and Westchester counties);~~

~~(iii) Upstate standard metropolitan statistical areas;~~

~~(iv) Upstate non-SMSA.~~

~~(3) Geographic areas for medical facilities other than hospitals.~~

~~(i) Western New York hospital service region;~~

~~(ii) Rochester hospital service region;~~

~~(iii) Central New York hospital service region;~~

~~(iv) Northeastern New York hospital service region;~~

~~(v) Long Island hospital service region;~~

~~(vi) Northern Metropolitan hospital service region;~~

~~(vii) New York City hospital service region.~~

~~(4) Size of medical facility.~~

~~(i) Teaching hospitals, smaller programs.~~

~~(a) Up to 100,000 patient days;~~

~~(b) 100,001 to 125,000 patient days.~~

Continued

- ~~(c) 125,001 to 150,000 patient days;~~
~~(d) 150,001 and over patient days.~~
- ~~(ii) Teaching hospitals, larger programs:~~
- ~~(a) Up to 175,000 patient days;~~
~~(b) 175,001 to 225,000 patient days;~~
~~(c) 225,001 and over patient days.~~
- ~~(iii) Voluntary general, non-teaching (NYSMSA):~~
- ~~(a) Up to 25,000 patient days;~~
~~(b) 25,001 to 50,000 patient days;~~
~~(c) 50,001 to 75,000 patient days;~~
~~(d) 75,001 to 100,000 patient days;~~
~~(e) 100,001 and over patient days.~~
- ~~(iv) Voluntary general, non-teaching (Upstate SMSA):~~
- ~~(a) Up to 25,000 patient days;~~
~~(b) 25,001 to 50,000 patient days;~~
~~(c) 50,001 to 80,000 patient days;~~
~~(d) 80,001 and over patient days.~~
- ~~(v) Voluntary general, non-teaching (non-SMSA):~~
- ~~(a) Up to 15,000 patient days;~~
~~(b) 15,001 to 30,000 patient days;~~
~~(c) 30,001 to 45,000 patient days;~~
~~(d) 45,001 to 75,000 patient days;~~
~~(e) 75,001 to and over patient days.~~
- ~~(vi) Public, non-teaching:~~
- ~~(a) Up to 20,000 patient days;~~
~~(b) 20,001 to 40,000 patient days;~~
~~(c) 40,001 and over patient days.~~
- ~~(vii) Proprietary, non-teaching:~~
- ~~(a) Up to 20,000 patient days;~~

(a) (1) For the purpose of establishing routine and ancillary cost ceilings, peer groups of hospitals shall be developed taking into consideration for teaching hospitals the following variables:

- (i) Certified Beds
- (ii) Percent Medicaid
- (iii) Percent Medicare
- (iv) Percent Blue Cross
- (v) Service Index
- (vi) Special Beds Ratio
- (vii) Teaching Ratio
- (viii) Number of Teaching Programs;

and for non-teaching hospitals the following variables:

- (i) Certified Beds
- (ii) Percent Medicaid
- (iii) Percent Medicare
- (iv) Percent Blue Cross
- (v) Service Index
- (vi) Ratio of Admissions from Emergency Room to Total Admissions
- (vii) Ratio of Surgical Procedures to Total Admissions

(2) For the purposes of establishing individual hospital ceilings on the cost of routine inpatient services for each hospital stay, a peer group of hospitals shall be developed which shall take into consideration for teaching hospitals the following variables: (i) size and (ii) influence of geriatric patients and for non-teaching hospitals: (i) size and (ii) influence of geriatric patients.

(b) Where one group contains an insufficient number of medical facilities needed to establish a reimbursable ceiling, such institutions shall be considered as part of another comparable group.

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(c) Facilities with costs less than 75 percent or over 125 percent of the weighted average cost of the group will be excluded from the ceiling computation. Such facilities will be subject to any ceilings developed on the basis of the facilities remaining in the group.

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(d) In the event a hospital fails to submit the data required for inclusion in a group developed in accordance with subdivision (a) of this section, the Commissioner of Health, on the basis of data available, shall identify the hospital with a developed group and the costs of such hospital shall, for reimbursement purposes, be limited to the group ceilings.

86-1.14 Ceilings on payments. (a) Ceilings as specified in this section for comparable groups of medical facilities will be established for the computation of reimbursement rates for care provided. The ceilings shall be considered prior to the addition of a factor to bring costs to projected expenditure levels

(a) Continued

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during the effective period of the reimbursement rate.

(b) In computing the allowable costs for inpatient routine services for hospitals no amount shall be included (1) that is in excess of the weighted average per diem cost of routine inpatient services of all hospitals in the group, and (2) that reflects inpatient routine costs incurred in providing services for days in excess of the weighted average length of stay of all hospitals in the group developed for this purpose/ up to a maximum of two days. However, when medical facilities with penalties resulting from an excessive length of stay in the base year have demonstrated a reduction in their length of stay to the group average or lower, the penalty will be removed. For the purpose of this computation, routine inpatient services shall not include capital costs, costs of schools of nursing, costs of interns and residents, and costs of ancillary services. In computing the allowable costs for ancillary services for hospitals, no amount shall be included that is in excess of the weighted average cost of ancillary services per discharge. For the purpose of this computation, ancillary services shall not include capital costs, costs of schools of nursing, costs of interns and residents and costs of routine inpatient services. Effective with base year 1975, hospitals determined at any time during the base year for rate computation purposes to be providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council shall not be included in their appropriate groups for the purpose of determining ceilings, but will be subject to any ceilings developed on the basis of facilities remaining in the group.

(c) In computing the rates for care provided by community based home health agencies, no amount may be included in a rate that is in excess of the agency charges or in excess of 110 percent of the weighted average cost of all agencies in their group. For hospital based home health agencies, no amount may be included in a rate that is in excess of 110 percent of the weighted average cost of community based agencies in their area.

(d) (1) In computing the medical facility rates for methadone maintenance treatment programs, no amount shall be included that is in excess of:

(i) For treatment and diagnostic centers, the cost included in the rate for employees' salaries and fringe benefits shall not exceed 115 percent of the customary employee cost, as determined by the commissioner, by geographic area, required to staff a facility based on care to 300 patients. Such computation shall be based on an allowable staffing consisting of the full time equivalent of one physician, two nurses, six counselors, two vocational specialists, one clinic administrator and six additional non-professional employees.

(ii) For hospital based methadone maintenance treatment programs, the rate shall not exceed 150 percent of the ceilings, by geographic area, as determined in subparagraph (i) of this paragraph.

(2) The State Commissioner of Health may waive the ceiling limitations of this subdivision for those which have received the prior budget approval of a State agency and such agency finds and recommends to the State Commissioner of Health that he determines that such costs are reasonably related to the costs of efficient production of such services.

~~(e) Hospitals operated by the Health and Hospital Corporation will be identified with respect to type and size with the appropriate group of voluntary facilities developed in accordance with Section 86.13 and any ceilings established for the voluntary group of facilities will be applied to such hospitals.~~

86-1.15 Adjustments to basic computed rate. (a) Payment rates shall be established on a prospective basis.

.. . . .

(b) To the allowable basic rate, computed in accordance with ceiling 52 limitations, and prior to the addition of capital costs, realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a medical facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.

(ii) Nonpayroll administrative and general expense.

(iii) Nonpayroll household and maintenance expense.

(iv) Nonpayroll dietary expense.

(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories.

Included among these cost indicators are elements of the United State Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) In the determination of 1977 rates and any adjustment to the 1976 rates in accordance with paragraph 86-1.15(b)(4) the Commissioner may compute the 1976 trend factor in the 1977 rate and any adjustment to the 1976 rate by using the lower of external indicators or actual change in salaries and fringe benefits.

(5) During the rate period the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of

: 77 7

(5) Continued

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mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

~~86.16 Final rates. No retroactive adjustments shall be made in rates certified pursuant to this Part. This shall not preclude rate adjustments to correct errors in the determination of such rates. However, errors resulting from submission of information by a medical facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulting from the rate computation process may be corrected if brought to the attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.~~

86-1.16 Adjustments to Provisional Rates Based on Errors.

Errors resulting from submission of information by a medical facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the Commissioner's rate computation sheet. Errors on the part of the State Department of Health resulting from the rate computation process may be corrected if brought to the attention of the Commissioner within four months of receipt of the Commissioner's rate computation sheet.

may consider only those applications for prospective revisions of certified rates which are based on:

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a medical facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 86.16;

(3) significant increases in the over-all operating costs of a medical facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a medical facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the medical facility by the Commissioner;

(5) requests for waivers of any provisions of Part 86 for which waivers may be granted by the Commissioner as prescribed in specific sections;

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(7) requests for relief from the ceiling provisions of section 86-1.14(b) of this subpart. For such relief, a medical facility must demonstrate that its range of approved services, patient mix, [lengths of appropriate stays] or other pertinent factors are direct causes for all or part of the costs in excess of the [routine or ancillary] said ceilings. Such relief shall

not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the commissioner. If relief is granted, the resulting revised rates shall become effective as of the first day of the rate period with respect to the routine per diem and ancillary per discharge ceilings. With respect to relief from the ceiling on cost of routine inpatient services per hospital stay the effective date of a revised rate will be the first day of the first month of a six month period used to demonstrate a reduced length of stay to the group average or the first day of the rate period if relief is granted on other factors.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) - (h) on pp. 24a & 24b
86-1.18 Rates for services (a) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, separately identify all inclusive prospective rates for inpatient services, emergency services (and), clinic services and such other services for which a separate rate is deemed appropriate by the Commissioner.

(b) Payment for newborns shall be made at one-third of the mother's rate.

(c) Payments by governmental agencies and corporations organized and operating in accordance with article IX-C of the Insurance Law for days of care in excess of 60 consecutive days for inpatients in a general hospital shall be at an amount equal to the rate promulgated less 16.67 percent of such rate unless the facility has in operation an effective program of control over utilization of such services which is in compliance or consistent with regulations and requirements certified or approved by the State Department of Health for medical utilization review of inpatient services.

(c) In view of the commissioner's responsibility for rates paid by government agencies and article IX-C corporations, and for revisions in such rates, each medical facility shall elect for the remainder of its rate period, whether such request covers the government agency rate, the article IX-C rate or both. The existing review procedures employed by article IX-C corporations are in no way intended to be affected by this subdivision.

(d) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(e) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the commissioner shall notify the requesting party of his determination.

(f) In reviewing appeals for revisions to certified rates the commissioner may refuse to accept or consider an appeal from a medical facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council in one of its facilities;

(3) where it has been determined by the commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law.

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances subdivision (d) of this section shall not be effective until 57
the date the appeal is accepted by the commissioner.

(g) Any facility determined after review by the State Hospital Review and Planning Council during a rate year to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(h) Per diem inpatient rates for hospitals shall be adjusted during each rate period to provide for the underpayment or overpayment of costs attributable to the prior year actual utilization being above or below that used in the rate calculation for the prior year, exclusive of minimum utilization adjustments as provided for in section 86-1.9 of this Subpart. In the determination of this adjustment variable costs will be excluded in the calculation and utilization changes of five percent or less will be disregarded.

(d) The State Commissioner of Health shall, in certifying schedules for government payments to hospitals, establish one all inclusive prospective rate for inpatient hospital care to reflect the services provided by each facility possessing a valid operating certificate. In addition, the Commissioner shall identify and certify all inclusive prospective rate for emergency services, clinic services and for such other services as deemed appropriate.

86-1.19 Rates for medical facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

- (a) The usual and customary rates, for comparable services, in the geographic area.
- (b) Satisfactory cost projections.
- (c) Allowable actual expenditures.
- (d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

86-1.20 Less expensive alternatives. Reimbursement for the cost of providing services [shall ^{may} be] the lesser of the actual costs incurred or those costs which could be reasonably anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served as effective alternatives or substitutes for the whole or any part of such services. In this respect, the chief executive officer of a medical facility will be required to submit to the State Department of Health as an attachment to the Uniform Financial Report, effective with report periods beginning on or after January 1, 1977, an affidavit delineating the medical facility's practices of pursuing joint central services or less expensive alternatives. There must be a letter accompanying the affidavit, reflecting the Health Systems Agency's acknowledgement that they have received such affidavit.

86-1.21 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the commissioner, allowable costs shall be determined

by the application of the principles of reimbursement developed for determining payments under the Title XVIII (medicare) program.

(b) Allowable costs may not include costs for open heart surgery or renal dialysis, except for emergencies, in facilities not approved by the State Commissioner of Health for this service.

(c) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a facility.

(d) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(e) Allowable costs shall not include expenses or portions of expenses reported by individual facilities which are determined by the commissioner not to be reasonably related to the efficient production of service because of the nature or amount of the particular item.

(f) Any general ceilings applied by the commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(g) Reserved

(h) Allowable cost shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to their owners, operators or employees.

(i) Allowable costs shall not include any interest charged or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(j) Allowable costs shall not include the direct or indirect costs of advertising, public relations or promotion except in those instances where the

(j) Continued

advertising is specifically related to the operation of the facility and not for the purpose of attracting patients.

(k) Effective for fiscal years ending in 1976 and thereafter allowable costs per unit of service (inpatient day, clinic visit, etc.) in a base year will not include any cost increases over the allowable costs in the prior year which are in excess of the inflation factor used by the Department in determining the reimbursement rate in effect during such base year unless the cost increases in the base year resulted in a rate revision related to such year in accordance with §86.17.

(l) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(m) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the commissioner, to be allocable to expenditures other than for public relations, advertising, or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the commissioner pursuant to section 86.21(f).

86-1.22 Recoveries of expense. (a) Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

- (1) drugs and supplies sold for use outside the medical facility;
- (2) telephone and telegraph services for which a charge is made;
- (3) discount on purchases;
- (4) living quarters rented to employees;
- (5) employee cafeterias;

- (6) meals provided to special nurses or patients' guests;
- (7) operation of parking facilities for community convenience;
- (8) lease of office and other space of concessionaires providing services not related to medical service;

(9) tuitions and other payments for educational service, room and board and other services not directly related to medical service.

86-1.23 Depreciation. (a) Reported depreciation based on historical cost is recognized as a proper element of cost.

(b) In the computation of rates effective January 1, 1975 for voluntary facilities, depreciation shall be included on a straight line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the years' digits method. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates (effective January 1, 1975) for public facilities, depreciation is to be included on a straight line method on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digits method.

~~(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight line basis on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum of the years' digits method.~~

(d) In the computation of reimbursement rates for proprietary facilities, depreciation is to be computed on a straight line basis on plant and non-movable equipment. Depreciation on movable equipment may be computed on a straight line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(e) Medical facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirement of the Subpart. In lieu of depreciation and interest, on the loan financed portion of the facilities, ~~[as allowable costs, however]~~ the State Commissioner of Health shall allow level debt service on the mortgage loan, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness.

(f) Article IX-C Corporations may elect to include in their reimbursement rates depreciation computed by a method other than that used in subdivisions (b), (c) and (d) of this section, subject to approval by the commissioner.

86-1.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all medical facilities.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

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(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

(d) Interest on capital debt in excess of 50 percent of the net depreciated value of buildings and fixed equipment for voluntary facilities shall not be considered an allowable cost unless the State Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested parties that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

(e) Interest on capital debt incurred in part or in whole after July 1, 1971 that is in excess of 75 percent of the net depreciated value of buildings and fixed equipment for proprietary facilities shall not be considered an allowable cost. In instances where capital debt exceeds 75 percent of such value and the amount of interest considered as an allowable cost is limited, the computation of the reimbursement rate shall include either an amount equal to the amount which would have been included under section 86.29 of this Part had the operators invested additional capital equal to the amount on which interest is not considered an allowable cost or the interest paid, whichever is lower. In no event shall the total amount on which either interest or return on equity is computed exceed such net depreciated value. In these cases, return on equity shall be computed on the basis of the percent return in effect as of the date on which the debt was incurred. Interest related to refinanced mortgage indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid

principal of the mortgage then being refinanced and only if such indebtedness is equal to or less than the then undepreciated capital cost of the facility. To the extent that refinanced mortgage indebtedness is in excess of the then unpaid principal of the mortgage being refinanced or is greater than the then undepreciated capital cost, the amount of such excess shall be deemed to be a return of equity, requiring recomputation of the return on investment allowance for net equity capital as such return on investment is computed pursuant to the provisions of section 86.29 of this Part. In order to qualify as allowable costs, all expenses related to the refinancing of mortgage indebtedness shall be economically necessary to the continued operation of the facility. If qualified refinancing results in lower property costs, an appropriate downward adjustment in rates shall be made.

86-1.25 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86-1.27 Compensation of operators and relatives of operators. (a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable costs. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

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(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

86-1.28 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to the medical facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies and a return on the equity capital of the related organization.

86-1.29 Return on investment. (a) In computing the allowable costs of a proprietary medical facility, there shall be included an allowance of a reasonable return on the net equity capital representing the investment by an owner used for the provision of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner as reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for these assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation, and working capital for necessary and proper operation for patient care activities.

86-1.30 Capital cost reimbursement. (a) The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86.23, 86.24, 86.29 of this part and all such costs shall be approved in amount and nature by the Commissioner of Health as he shall determine is appropriate, proper and in the public interest, and be certified and audited as actually having been expended; provided, however, that;

(1) with respect to a facility for which a rate has been determined and certified by the Commissioner of Health prior to March 10, 1975, the Commissioner of Health may continue such method and computation of such rate or make such modifications and changes to lower such rate as in his judgment are necessary and proper and in the public interest; and

(2) with respect to a facility which has been established by the Public Health Council, and for which a rate has not been determined and certified by the Commissioner of Health prior to the effective date of this section, and a legally binding arms length lease was the basis for the establishment approval granted by the Public Health Council, the Commissioner of Health may determine and certify a rate on the basis of such lease.

86-1.31 Termination of Service. The Division of Health Care ~~[Economics]~~ Financing in the Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service

and the cost impact on the medical facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-1.8 (f) of this Subpart.

86-1.32 Sales, leases and realty transactions. (a) If a medical facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the Commissioner of Health, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86.23, 86.24, 86.29 and 86.30 of this Part.

(b) If a medical facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be considered to be continuing with the same force and effect as though such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations generally under section 86.30 of this Part, or specifically when based upon previous error, deceit or any other misrepresentation or misstatement that has led the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to such a facility is terminated.

~~86-1.33 Reserved~~

86-1.33 - Repealed

~~86-1.34 Interim rules for residential health care facilities. For the purpose of reporting and rate certification for residential health care facilities, the Part 86 rules in effect on October 8, 1975, shall remain in effect for an interim period until regulations have been promulgated pursuant to §§ 2607 and 2608 of the Public Health Law. The provisions of sections 86.15(b)(4), 86.17(a)~~

E. J. 127⁶⁹ 12

Foregoing provisions contains all of Part 86 with exception of 86 -1.26 which authorizes the inclusion of educational activities less tuition and supporting grants shall be in the calculation of the basic rate provided such activities are directly related to patient care services, and which eliminates a portion of costs related to salaries and fringe benefits for interns and residents and supervising physicians for purposes of reimbursement, from rate computations on the basis that this elimination represents the minimum amount properly chargeable to education activities not directly related to patient services.

~~26-1.34~~ Continued

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~~and (b), and 26.21(k), filed with the Secretary of State on November 26, 1975~~
~~apply to residential health care facilities as of said date.~~

~~26-1.34~~ Repealed

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

-----X
HOSPITAL ASSOCIATION OF NEW YORK STATE,
INC., et al.,

Plaintiffs,

- against -

PHILIP L. TOLA, as Commissioner of Social
Services of the State of New York, et al.,

Defendants.
-----X

SUPPLEMENT TO OPINION
OF MAGISTRATE DATED
JUNE 1, 1977

76 Civ. 2027 (MEL)

By letter dated June 7, 1977, referring to my opinion dated June 1, 1977, counsel for the State defendants state that they do not intend to withdraw Interrogatory 10 dealing with the groupings of hospitals, as stated in my opinion. At a hearing before me on July 5, 1977 counsel for the State defendants sought clarification of plaintiffs' position with respect to this interrogatory. Plaintiffs' counsel stated that they are not challenging in this action the application of the groupings to the State plan. However, counsel stated that plaintiffs' position is that in view of the 100 percent ceiling on reimbursement, contrasted with the prior 110 percent ceiling, the present groupings are too broad, are not sufficiently refined, and hence are arbitrary.

Dated: New York, New York
July 5, 1977

Martin D. Jacobs

Martin D. Jacobs
United States Magistrate

PROSKAUER ROSE GOETZ & MENDELSON

300 PARK AVENUE

NEW YORK, N. Y. 10022

TELEPHONE: (212) 593-9000

WRITER'S DIRECT DIAL NUMBER

593-9202

ALFRED L. ROSE
WALTER MENDELSON
ALFRED APPER
WILFRED H. FRIEDMAN
CHARLES LOOKER
HOWARD LICHTENSTEIN
JAMES J. FULD
GEORGE M. SHAPIRO
GERALD SILBERT
WILLIAM P. HIGGINS, JR.
EDWARD SEYER
PHILIP J. NIRSCH
JACOB IMBERMAN
ROBERT DILLON
GEORGE G. GALLANTZ
ROBERT J. LEVINSOHN
ANDREW D. RZINEMAN
BERNARD GOLD
RUTH O. SCHAPIRO
KLAUS EPFLER
HOWARD A. SHAPIRO
MARTIN J. OPPENHEIMER
ALAN S. ROSENBERG
LARRY M. LAVINSKY
STEPHEN P. KAYE
STANLEY KOMAROFF

IRA E. LUSTGARTEN
MARVIN DICKER
SAUL O. KRAMER
ROBERT M. KAUFMAN
RONALD S. SCHACHT
MORTON M. MANEKER
JEROLD ZIESELMAN
DAVID I. GOLDBLATT
YALE H. GELLMAN
ARNOLD J. LEVINE
HOWARD N. LEFKOWITZ
BERNARD TANNENBAUM
HARVEY E. BENJAMIN
ALAN S. JAFFE
DAVID J. STERN
STEVEN J. STEIN
MICHAEL A. CARDOZO
L. ROBERT BATTERMAN
HOWARD L. GANZ
PAUL H. EPSTEIN
LAWRENCE J. ROTHENBERG
RONALD S. RAUCHBERG
STEPHEN A. MINTZ
BRUCE S. WOLFF
GAIL SANGER HAPPERIN

WILLIAM H. ROSE
(1878-1931)

JOSEPH M. PROSKAUER
(1930-1971)

NORMAN S. GOETZ
(1925-1972)

CABLE: ROPUT
TELEX: ITT 42117
WU 12535

August 11, 1977

Hon. Morris E. Lasker
United States District Court
Southern District of New York
Foley Square
New York, New York 10007

Re: Hospital Association of New York
State v. Toia, et al., 76 Civ. 2027 (MEL)

Dear Judge Lasker:

Late Tuesday afternoon we received the State Defendants' proposed order submitted in accordance with your memorandum opinion dated August 4, 1977. We are primarily concerned with the last decretal paragraph of the order which would have plaintiffs refund monies paid to them pursuant to your judgment of August 2, 1976. Restitution was never referred to in the State Defendants' motion papers, was not briefed by either side, and was not referred to in your Honor's opinion. The amounts involved are so substantial that if the hospitals were required to refund these monies their ability to furnish health services to the people of the State would be seriously impaired.

There is in reality one basic reason why the State Defendants are not entitled to restitution. In 1976, your Honor found that the State Defendants acted "in blatant disregard" of federal law when they attempted to implement amendments to the State Plan before they had been approved by the Secretary of Health, Education and Welfare. Your judgment directed that the hospitals be reimbursed in accordance with the then approved State Plan. This resulted in some hospitals receiving reimbursement at rates higher than they received either prior to your judgment or as a result of the amendments ultimately approved by the Secretary. The State

Hon. Morris E. Lasker

August 11, 1977
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Defendants have never seriously questioned the propriety of your Honor's ruling on pre-implementation approval. Your opinion of last week reiterates that holding. Under these circumstances it seems to us highly inappropriate and demonstrably inequitable for the State Defendants to ask you now to order the hospitals to return the money which both last year and this year your Honor has held they were entitled to receive.

It is a long established principle of law that restitution is an equitable remedy granted only when justice requires. One of the more recent instances in which federal courts have so held is Thompson v. Washington, 551 F.2d 1316 (D.C. Cir. 1977). In that case the court refused to order restitution of rent increases which it found to have been illegally imposed. The court viewed the request for restitution as follows:

"The basic question is whether 'the money was obtained in such circumstances that the possessor will give offense to equity and good conscience if permitted to retain it,' and is 'no longer whether the law would put him in possession of the money if the transaction were a new one.' Since restitution is not a matter of right, but is 'ex gratia, resting in the exercise of a sound discretion,' it lies within our authority to direct restitution in an amount less than the whole sum of the increased fares collected under the invalid order, or to deny it altogether, if compelling equitable considerations so dictate."

Id. at 1319, quoting Williams v. Washington Metropolitan Area Transit Commission, 415 F.2d 922, 944 (D.C. Cir. 1968) (en banc), cert. denied, 393 U.S. 1001 (1969) (emphasis supplied).

Your opinion of last week was based on jurisdictional grounds and does not affect the plaintiffs' substantive rights to receive the monies paid to them for the period from January 1, 1976 through the date of the Secretary's approvals. Moreover, at the time your Honor entered the judgment, you had jurisdiction to do so since the State Defendants' waiver of Eleventh Amendment immunity was in full effect.

The State Defendants' proposed order really asks your Honor to sanction illegal conduct. This we are sure your

Hon. Morris E. Lasker

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Honor would never do. Quite to the contrary, it has always been a fundamental canon of federal law that a state will obey the direction of a federal court even in the absence of a specific injunction. For example, in Wulff v. Singleton, 508 F.2d 1211 (8th Cir. 1975), rev'd on other grounds, 428 U.S. 106 (1976), the Court of Appeals declared a Missouri statute relating to abortions unconstitutional but did not enter an injunction against the State. In so doing, the Court said:

"We assume that the state will abide by the ruling of this court and that medical assistance payments will be made on a non-disparate basis to those eligible needy persons who elect to carry their pregnancy to term or who receive therapeutic abortions and also to those who elect non-therapeutic abortions."

Id. at 1216

Because of the basic inequity of the State Defendants' request, we think it should be rejected out of hand. If your Honor does not agree with us at this time, we request the parties be given a reasonable opportunity to brief the issue of recoupment and then submit such arguments as your Honor would care to hear.

Respectfully yours,

Jacob Imberman

cc: Robert Sayler, Esq.
John O'Connor, Esq.
Peter Nadel, Esq.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

HOSPITAL ASSOCIATION OF NEW YORK
STATE, INC., et al.,

Plaintiffs,

-against-

76 Civ. 2027
(MEL)

PHILIP L. TOIA, as Commissioner of
Social Services of the State of
New York, et al.,

Defendants.

The Deposition of GEORGE B.
ALLEN, was held, pursuant to Notice, at
the New York State Health Department,
14th Floor, Tower Building, Empire State
Plaza, Albany, New York, on Tuesday,
August 23, 1977, at 10:00 a.m., before
Mary Fritz, Notary Public in and for the
State of New York.

Allen

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tive system, in my definition, a system in which the hospital does not know of its rate until very late in the year in which it is providing the services under that unknown rate. It is thus a subject of the incentives of a prospectively determined rate.

FURTHER DIRECT EXAMINATION

BY MR. SAYLER:

Q Okay, I understand that.

At Page 54, the preceding page, the second paragraph, which starts: "When major proposals--" would you mind reading that?

(Witness refers to document).

A Yes.

Q You told HEW, that it does not seem appropriate to consider major proposals only singly and in the abstract.

I am paraphrasing, but I am reading in part from that.

A Yes.

Q What is the reason for that?

MR. IMBERMAN: For what?

Allen

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FURTHER DIRECT EXAMINATION

BY MR. SAYLER:

Q That your belief that--do you actually believe that?

A Yes.

Q Okay, why?

A You can in no way determine whether a hospital is being reimbursed reasonable costs if you only look at one piece of the plan without comparing it for the total plan and then further without comparing it to the total reimbursement system in the State, including the effect on other providers, and I make reference to the coupling with Blue Cross.

Q Thank you. Mr. Allen, I want to be quite clear on one point.

In this litigation is HANYS challenging only the changes between the 1975 and 1975 Methodology?

THE REPORTER: Did you say the same date?

MR. SAYLER: I said the

Exh. 11

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Hospital Association of New York State

15 COMPUTER DRIVE WEST ALBANY, NEW YORK 12205 (518) 456-77

August 23, 1976

150062

TO: Chief Executive Officers
Member Hospitals

SUBJECT: HEW § Part 86

On August 11, 1976, representatives of the Association met with staff of Region 11 of HEW to present the views of the health care industry relative to amendments which had been proposed by New York State to its Medicaid Plan (of which Part 86 is a portion). The meeting was held to acquaint HEW with the shortcomings and inequities in these amendments.

The presentation to HEW is attached. It is lengthy but the discussion contained therein will be helpful to you in understanding the complexities of the amendments and also in explaining them to your board and staff. It also serves as an excellent document for summarizing the views of HANYS for use in further appeal and/or litigation.

The document was prepared under intense time pressure because HEW allowed only three working days notice for the Association to present its case. The final product represents a joint effort between HANYS staff, the law firm of Proskauer Rose Goetz & Mendelsohn and staff of Mt. Sinai Hospital (one of the plaintiffs in the legal action). We are indebted to these people for their efforts as well as to those administrators and others who participated in the August 11 meeting.

We urge you find the time to review the document.

Sincerely,

George B. Allen

George B. Allen
President

102A

cc: Personal Members

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Albany
Chairman Elect
IRVING G. WILLIAMS
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Past Chairman
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1978

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President
GEORGE B. ALLEN
Albany

STATEMENT OF HOSPITAL ASSOCIATION
OF NEW YORK STATE
TO
OFFICE OF REGIONAL COMMISSIONER
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
NEW YORK, NEW YORK
August 11, 1976

This statement is made on behalf of the Hospital Association of New York State -- "HANYS" -- the organization of voluntary nonprofit and public hospitals in New York State. HANYS appreciates the opportunity to appear before you today to put on the record its views on certain proposed amendments to the New York State Medicaid Plan.

We recognize the circumstances under which these hearings are held. They are, we believe, in large part the result of the issuance of an injunction by Judge Morris E. Lasker of the United States District Court for the Southern District of New York preventing the implementation of these amendments without HEW approval. I believe it appropriate at this time to make part of your official record the affidavits and exhibits submitted to the Federal Court, and the transcript of the hearing before it. These are Exhibit I to our statement.

We are not blind to the fact that many of the proposed amendments (though clearly not all of them) may be motivated by the fiscal crisis faced by the State of New York and its localities. In fact, testimony before Judge Lasker indisputably showed that a number of the regulations in these amendments (including the establishment of the 100% ceilings) were essentially aimed at achieving the pre-established result of a fixed total expenditure by the State, rather than a determination of reasonable cost.

Unfortunately, consideration of the proposed regulations and of the State's fiscal crisis seems to be taking place in a climate in which it is assumed, without further argument, that there is "galloping inflation" in hospital costs. In fact, it should be recognized that New York hospitals have been responding to cost control regulations and laws, and that the rate of increase in hospital costs in New York is substantially the same as cost increases in the economy as a whole. In the view of hospital experts, the increase in real dollar costs in New York hospitals is primarily attributable to new programs and facilities approved by the State Health Department and for the necessary introduction of new scientific techniques.

We do not approach the present situation with an attitude of irreconcilable opposition to any reasonable action by the State to reduce excessive costs. In fact, the hospital industry has suggested to the State a number of ways in which substantial savings could be achieved in both hospital and non-hospital Medicaid expenditures. These include the improvement of claims administration, the elimination of ineligible claims and the reduction of excessive utilization. Should the proposed amendments be rejected by your Agency, as they should be under Federal law and regulations, the hospital industry of New York is prepared to sit down with the appropriate State agencies, as it has offered to do in the past, to work out reasonable approaches both to the State's problems and those of the hospitals. This is, in fact, the approach contemplated by the Medicaid program which encourages State agencies to involve representative provider organizations in the development of Medicaid plans (45 CFR §250.30 (a)(2)).

But we strongly oppose arbitrary and unlawful reductions in reimbursement to providers of the reasonable cost of hospital services to Medicaid beneficiaries. As we will point out, the proposals of the State, which it has already attempted to implement without HEW approval, not only do not result in the required payment of reasonable cost; they in fact preclude payment of reasonable cost.

I should point out in the very beginning that our comments today are limited to the provisions in Part 86 of the Rules and Regulations of the Commissioner of Health of the State of New York, which have been submitted for incorporation into the New York State Plan for Medical Assistance under Attachment 4.19-A. This attachment contains the description of the State's methodology for determining and paying the reasonable costs of in-patient hospital services. We understand that there are also pending before you other amendments to the State Plan, including provisions which comprise what is now called Part 85 of the Commissioner's Rules and Regulations, relating to limitations on allegedly postponable surgery, pre-operative hospital stays, total hospital stays and similar amendments. We have not prepared testimony on Part 85 for this session, but would like to have our comments on those provisions considered by you prior to any action on Part 85. We understand that the State Medical Society would also like to comment on these provisions.

Supposedly, the provisions of Part 86 are to result in a determination of the reasonable cost of in-patient hospital services for Medicaid purposes under the State Plan. While we believe that Part 86, as first submitted, may well have had this result, we do not believe that Part 86, as proposed to be changed by the amendments which are before you, can possibly result in a determination of the reasonable cost of in-patient

hospital services by hospital providers in New York State. In fact, we believe that if Part 86 is amended as the State proposes, it will prevent the determination and payment of such reasonable cost.

I think it is worth noting the process by which amendments to Part 86 are adopted by the State. Until early 1976, despite what appeared to be specific provisions in State law and the often-expressed views of the hospital industry, the State Commissioner of Health adopted amendments to Part 86 on his own responsibility, although Section 2803 of the State Public Health Law required such regulations to be promulgated by the State Hospital Review and Planning Council and thereafter to be approved by the Commissioner. Following an opinion rendered by the State Attorney General to the effect that adoption by the Council was required by law, the State Commissioner of Health submitted all of Part 86, including many new provisions not previously included, to the State Hospital Review and Planning Council for re-enactment and such re-enactment took place on April 8th, 1976, after only a few minutes of discussion. That re-enactment contains many of the provisions which we challenge here, although it is worth noting that one of the provisions under discussion (§86.26 relating to interns and residents) was rejected by the Council on that and a subsequent occasion, and has nevertheless been promulgated by the Commissioner on his own authority.

It is also worth noting that the State has consistently failed to give any real voice to hospitals in the development of health care policy, an omission which violates the spirit of 45 CFR §250.30 which encourages participation by providers. The State has also ignored the Medical Advisory Committee required both under 45 CFR §246.10 and state law in developing its Medicaid policies. In fact, this Committee has not met in over a year. It should also be noted that the regulatory process presently in operation in the State of New York, under which all of these regulations have been adopted, does not involve either notice or an opportunity for hearing or comment by those affected, although this will hopefully be corrected in the future, since the State Legislature has enacted an administrative procedures act, to become effective on September 1, 1976, which should thereafter give such opportunity for hearing.

It is important to understand the history of the 1976 Medicaid rate determinations in New York in order to fully evaluate the purpose and result of the proposed amendments and the validity of State assurances as to how they will be implemented. When 1975 rates were promulgated, they were based upon trending factors taking into account the impact of inflation upon costs incurred in prior years. It was

assumed by all concerned -- State officials, hospital administrators, local officials and others -- that 1975 rates were certified for calendar year 1975 and that new rates would be promulgated for 1976 under existing State and federal law and regulations taking into account inflation factors for 1976. In fact, there was then on the books a section of the State Public Health Law requiring 1976 rates to be promulgated by the State no later than November 1, 1975. Such rates were not promulgated at that time and when January 1, 1976, arrived, the State continued to pay 1975 rates which at various times were described as frozen rates or interim rates subject to later adjustment. In any event, it was clear that they were the same rates that had been calculated only as payment of 1975 reasonable costs. Despite all efforts to get the State to promulgate new rates for 1976, the State continued to pay 1975 rates while also moving to secure enactment of legislation and approval of regulations which would authorize it to readjust its reimbursement system, both with respect to services already rendered during 1976, and with respect to services still to be rendered. Finally, on July 1, 1976, the State announced new rates allegedly retroactive to January 1, which, as was pointed out in the hearings before Judge Lasker, are even less for some hospitals than their 1975 rates despite continued inflation. Many of the other rates contain increases in no way reflecting inflationary trends or other necessary

changes since 1975.

The major portion of our presentation will be directed at those proposed amendments which, in the opinion of hospitals, have the most deleterious and disastrous effect both in terms of preventing the payment of reasonable costs and in denying provider hospitals basic due process rights. We will, however, also comment on the somewhat less serious proposed amendments as well as on an alleged appeals procedure. We will then discuss the extremely important issue of the State's avowed intent, in violation of what we believe are clear requirements of federal law, to try to make any new provisions which you might approve retroactive to January 1, 1976. Finally, we will comment on the overall impact of the proposed changes in Part 86 which, the hospitals feel, will have the effect of eliminating the possibility of reasonable cost reimbursement to providers of in-patient hospital services under the New York State Plan. I hope that you will feel free to ask any questions you wish during our presentation.

With your permission, we will discuss the most important of the proposed revisions in an order other than they appear in Part 86, to tie together certain provisions which have a necessary relationship to one another.

SECTION 86.14(b)

We consider the most damaging proposal to be the new provisions of Section 86.14(b) imposing ceilings on routine and ancillary costs. We believe these provisions go to the heart of the reimbursement process and in fact necessarily result in the denial of reasonable cost reimbursement and an inevitable and accelerating deterioration of the health care system generally and the viability of hospitals in particular.

Substantial testimony was presented at the hearings before Judge Lasker to show that there was no particular evaluation by the State of whether routine and ancillary costs excess of 100% of the group average were unreasonable. In fact, the State's own worksheets, which we will submit to you as an exhibit, demonstrate that the State tested out the numerical results of placing ceilings at various levels, such as 95%, 97 1/2%, 100%, 105% and 110%, to see which would produce the desired Medicaid expenditure level. The establishment of reimbursement levels based not upon reasonable cost but upon the assumed availability of funds is not permitted by Federal law. This principle was most recently enunciated in this agency's publication of its new reimbursement regulations for skilled nursing and intermediate care facility services, 41 FR 27300, July 1, 1976. Despite the fact that Medicaid reimbursement for these services need only be on a reasonable cost-related

rather than reasonable cost basis, the availability of state funds was specifically rejected as a basis for limiting reimbursement. 41 FR 27303.

Section 86.14(b) does two things. It replaces the ceiling on routine per diem costs of 110% of the group average in the approved State Plan with a new ceiling equal to the group average itself. In addition, it imposes a new ceiling on ancillary service costs per discharge equal to the group average ancillary service cost per discharge, even though there are no ceilings on ancillary costs in the presently approved State Plan. Thus, on a weighted basis 50% of all hospitals (regardless of efficiency or other factors) will be in excess of the ceiling on routine per diem costs, and 50% of all hospitals (not necessarily the same ones) regardless of efficiency, will be in excess of the ceiling on per discharge ancillary service costs. In fact, one or the other of the ceilings affects more than 60% of all hospitals.

The basic flaws in the imposition of these new ceilings are the invalid assumptions that all efficiently run hospitals within a particular group should incur identical costs, and that an arithmetical average of such costs is a measure of hospital efficiency.

The use of average cost as a group ceiling assumes that all hospitals in a given group are alike and subject to identical influences on the level of costs incurred. This is clearly ridiculous since the groupings used by the State for classifying hospitals only take four criteria into account: type (teaching and non-teaching hospitals); geographical area for non-teaching hospitals; size; and sponsor (voluntary, public or proprietary). (10 NYCRR §86.13.) This classification system obviously does not include a great many factors which create natural differences in the costs of efficiently run hospitals. Such factors include patient mix, occupancy trends, design of plant, degree of unionization and intensity of care.

As to patient mix, no two hospitals will have an identical number of patients in their service departments - e.g., medicine, surgery, psychiatry. Even two hospitals with identical costs in each of their service departments will have varying average total costs if the mix of patients is not identical. This is illustrated by the example set out in our Exhibit II which I have available for reference herewith.

The illustration shows two hospitals with identical surgical patient per diem cost of \$200 and identical medical patient per diem cost of \$150. The two hospitals, however, vary in that the first has a higher proportion of surgical

patients and the second a higher proportion of medical patients. The difference in the patient mix results in an average cost for the hospital with the higher proportion of surgical patients almost \$7 greater than the average cost of the other hospital, even though their average per patient cost in each department is identical.

The use of discharges as the unit of measure in the calculation of the ancillary service cost ceiling is subject to the same failure to recognize the difference between patient mix in hospitals. This is illustrated by the example set out in our Exhibit III which I also have available for reference herewith. This shows that hospitals with identical lengths of stay for each type of patient will have substantially different total average lengths of stay, as a result of differences in patient mix, even though there is no difference in the average length of time a particular type of patient remains in the hospital.

Since total ancillary costs, even on a per discharge basis, depend upon the patient mix in the use of these services, hospitals with varying patient mix resulting in varying use of surgical suites, radiology departments, delivery rooms or physical therapy facilities must necessarily have different

average per discharge ancillary service costs, even though they may have identical costs within each department or ancillary service.

Occupancy trends will also affect the appropriateness of group ceilings established either at 100% of per diem or 100% of per discharge levels.

Since the routine and ancillary service cost ceilings are calculated by dividing routine service cost by patient days and ancillary service cost by discharge, it is obvious that a hospital which experiences a decrease in patient days is more likely to be hit by the ceilings than one showing an increase in patient days.

Design of plant also affects reasonable cost. Variations in the physical design of hospitals will influence their reasonable routine service costs. Every hospital's physical plant is different. Hospitals which have an older physical plant tend to require a greater degree of maintenance than more modern facilities. Some facilities require higher utility costs than others because of such structural characteristics as central air conditioning, or their location in the Con Edison rather than the Niagara Mohawk market area.

The design of a hospital may be such that its

different services are physically far apart. This results in higher costs because time is lost in transporting patients within the hospital. While modernization of all hospitals is desirable, this would require an enormous expenditure of capital funds which are clearly not available at the present time. Therefore, hospitals must continue to exist within the limits of their present facilities. It is unreasonable to penalize them for a situation over which they have little if any control.

The degree of unionization (and the extent to which some nonunion hospitals of necessity must follow union pay and fringe levels) with its attendant effect on pay scales and fringe benefits can produce significant variations in cost between hospitals. Both routine and ancillary costs can be affected since employee costs fall into both categories. For example, the cost of employees in the dietary department is essentially a routine cost, while the cost of a radiology department employee is an ancillary service cost. The effect of unionization is particularly significant with respect to fringe benefits which include paid time off. Unionized and such other hospitals pay approximately 18% for employee time off (e.g., vacations, maternity leave, paid holidays), while in non-unionized hospitals paid time off is roughly equal to 11 or 12 percent of total paid employee time.

Hospitals within the same group do not necessarily provide the same types of services. Some may concentrate on providing simpler, more low cost services such as obstetrical care and appendectomies. Others may provide high cost services such as open heart surgery, and orthopedic and cancer treatment. Obviously, hospitals of the latter type will incur higher costs. The effect of the ceilings is to deny reimbursement for some of the reasonable cost of providing this type of treatment, and discourage hospitals from making this care available to the public. The State cannot seriously suggest that the resulting deprivation of care increases hospital efficiency.

Clearly, any student of the hospital industry would recognize the foregoing factors and would accept the natural clustering of hospital costs above and below the mathematical average of a group as a direct result of these factors. The use of a group ceiling was never intended to penalize a hospital whose costs were reasonably close to the group average, but rather to protect the public from aberration in cost. It is obvious that whenever an average is used as a ceiling, some hospitals must exceed the average while others will be below it, regardless of their efficiency or the reasonableness of the costs they incur. As a result, even if every hospital in a group is operating at maximum efficiency,

some will still be hurt by the ceilings. This has more to do with the mathematical function of an average than the nature of the things being averaged.

I am advised that the concept of a ceiling based on a mathematical average is not used anywhere in the United States by any third party payor except in New York. I am also advised that no other third party payor uses a separate ceiling on ancillary cost or makes any calculation on a per discharge basis. Rather, there are used ceilings based either on a percentage above the average or the use of a fairly high percentile in an array of hospital costs such as is used by the Medicare program.

In contrast to the arbitrary ceilings included in §86.14(b), the Medicare program uses a ceiling on routine costs which allows for the natural fluctuation in hospital costs. This ceiling was selected after a great deal of study and deliberation by HEW, which has overall responsibility for the Medicare Program as well as the Medicaid Program. The Medicare ceiling is calculated by grouping hospitals and then taking the 80th percentile of a group's routine service cost and adding to it 10% of the median cost.

Exhibit IV shows the calculation of the Medicare

routine ceiling for a group of hospitals and then contrasts it with the Medicaid routine ceiling under §86.14(b) for the same group.

This table shows that a method for establishing reasonable ceilings on routine costs under the Medicare system would result for the same group of hospitals in a ceiling of \$97.50 per patient day under Medicare, with a single hospital affected by the ceiling, and a ceiling of \$75 per patient day under the State's proposed amendment, with five hospitals in the group affected. It is difficult to believe that such widely divergent results can represent reasonable costs under two federally sponsored programs.

On the basis of the Health Department's rate calculation sheets, it is apparent that more than 61% of the voluntary and public hospitals in New York have been adversely affected by the routine and ancillary ceilings. Any regulation which can have such an enormously negative impact must be considered unreasonable on its face. The fact that the State has included the adverse operation of these ceilings as a ground for an appeal mechanism not yet in operation does not make this regulation any less arbitrary or unreasonable. We shall comment separately on that appeal system. If the State is allowed to prevail, over 61% of the hospitals in New York will as a matter of course have to file an appeal in order to

obtain reasonable cost reimbursement. It is clear that the Medicaid Act and regulations do not contemplate placing such an inordinate and time consuming burden on health care providers, even if relief under such a system were actually and effectively available.

SECTION 86.13(c)

I think it is appropriate to discuss Section 86.13(c) at this point because of its close relationship to Section 86.14(b) and the effect it has of making even more unreasonable the rates determined in accordance with its ceiling provisions.

Section 86.13(c) appears eminently reasonable on its face. It provides that facilities with costs less than 75% or more than 125% of the weighted average costs of a group will be excluded from ceiling computations, but will be subject to the ceilings developed on the basis of the remaining facilities.

While this technique is supposed to be a statistical device to eliminate aberrant situations, it results in major distortions of data, almost always to the detriment of hospitals. We are submitting to you as our Exhibit V copies of the work sheets used by the Department of Health in calculating the

86.14(b) routine and ancillary service cost ceilings under 86.13(c). An obvious example of the prejudicial distortion in reasonable cost determinations created by §86.13(c) is to be found in the group covering teaching hospitals with over 100 residents and reporting less than 175,000 adjusted patient days in 1974. The data for that group is summarized for convenience in the separate sheet which we are submitting as Exhibit V A. It shows a group of 8 hospitals scattered throughout the state -- one in Buffalo, one in Syracuse, two in Nassau County, two in Brooklyn, one in the Bronx, and one in Manhattan. Of this group of 8 hospitals, five were eliminated by the 75%-125% rule in Section 86.13(c) from the group's ancillary cost ceiling calculation. Had all 8 hospitals been included in the average, the ancillary cost ceiling would have been \$604.32 per discharge. The exclusion of five hospitals and the establishment of an average based upon only three of them resulted in a ceiling of \$536.37, almost \$70 less for the group. Interestingly enough, two of these three hospitals were hit with penalties under the ceiling, even though both were under the average cost which would have been established for the entire group of 8 hospitals and which was used to define the 75%-125% limitation. Another example of distortion through the use of the 75%-125% corridor is the group identified as general nonteaching voluntary hospitals located in the Metropolitan New York

86.14(b) routine and ancillary service cost ceilings under 86.13(c). An obvious example of the prejudicial distortion in reasonable cost determinations created by §86.13(c) is to be found in the group covering teaching hospitals with over 100 residents and reporting less than 175,000 adjusted patient days in 1974. The data for that group is summarized for convenience in the separate sheet which we are submitting as Exhibit V A. It shows a group of 8 hospitals scattered throughout the state -- one in Sullivan County, one in Rochester, one in Syracuse, one in Queens, two in Brooklyn, one in Richmond and one in Manhattan. Of this group of 8 hospitals, five were eliminated by the 75%-125% rule in Section 86.13(c) from the group's ancillary cost ceiling calculation. Had all 8 hospitals been included in the average, the ancillary cost ceiling would have been \$471.59 per discharge. The exclusion of five hospitals and the establishment of an average based upon only 3 of them resulted in a ceiling of \$451.49 -- \$20 less for the group. Interestingly enough, two of these three hospitals were hit with penalties under the ceiling even though both were under the average cost which would have been established for the entire group of 8 hospitals and which was used to define the 75%-125% limitation. Another example of distortion through the use of the 75%-125% corridor is the group identified as general nonteaching voluntary hospitals located in the Metropolitan New York

Standard Metropolitan Statistical Area and reporting less than 25,000 patient days in 1974. For reference we have copied the data relating to this group onto a separate sheet which we are submitting as Exhibit V B.

As you will note, this group apparently consisted initially of 8 hospitals, one of which, Brooklyn Womens Hospital, was not considered at all because it had no inpatients in 1974. The 7 remaining hospitals included one, Swedish Hospital in Brooklyn, identified on the worksheets as having closed during September, 1975. In calculating the critical 100% ceilings for this group, five of the 7 hospitals were eliminated from consideration under the 75%-125% criteria and only two hospitals out of seven were considered in calculating the ceilings. The average ancillary cost for these two hospitals, which became the ceiling for the entire group, was \$293.74 per discharge. Interestingly enough, had all 7 hospitals in the group been included in the ceiling calculation, the average ancillary cost per discharge would have been \$277.01 -- \$16 lower.

There are certain aberrations in the group which should have been excluded from the ceiling computation. For example, Swedish Hospital, in its last full year of service, reportedly specialized in the treatment of alcoholic patients, and as a result had average ancillary costs per

discharge of only \$79, as compared to the general group average (including that hospital) of almost \$300. The elimination of this aberration alone would have raised the group average and thus the \$86.14(b) ceiling to \$374.65, thus radically reducing the penalties imposed. If both Swedish Hospital and the House of St. Giles The Crippled (a high ancillary cost hospital specializing in the care of crippled pediatric patients and also uncharacteristic of the other hospitals in the group) had been eliminated, the resulting average for the group would have been \$361.24 per discharge, almost \$70.00 higher than that resulting from the State's method of computation.

Other extremes can be found in the different group ceiling calculations -- particularly on the ancillary cost side which, as pointed out, was not previously subject to ceilings. In the smallest teaching hospital group, the use of the 75%-125% limit reduced the ancillary cost ceiling by \$55, from \$432.84 to \$377.50 -- about 15% of the total ancillary cost. In the group of large teaching hospitals with less than 175,000 patient days, the application of the 75%-125% limit reduced the ancillary cost ceiling by \$68, from \$604 to \$536 per discharge, or almost 13%. In this group 5 out of a total of 8 hospitals were eliminated from the ceiling calculation. In the group of upstate urban hospitals with 25,000 to 50,000 patient days, a group of

17 hospitals, seven hospitals were eliminated before the average was calculated, thus reducing the ancillary cost ceiling by \$28 - from \$287 to \$259, or over 10%.

As has been previously mentioned, there are some groups for which the use of the 86.13(c) method results in an increase rather than a decrease in the applicable ceiling. Yet, the number and amount of the increases are smaller than the decreases with respect to the imposition of both the routine and ancillary ceilings. Out of the 24 groups of voluntary and public hospitals used by the State, the 75%-125% provisions affects 13 with respect to routine costs. Seven groups have a lower average because of the use of this method. For more than half of these 7 groups the decrease in the average caused by 86.13(c) is between 5% and 10% with 6 of the 7 groups experiencing a decrease in excess of 2 1/2%. While the application of 86.13(c) results in increases for 6 groups, five of these six have increases of less than 2 1/2%. Equally striking is the impact on ancillary cost ceilings. Of the 24 hospital groups, only four are unaffected by the 75%-125% corridor. With respect to 13 groups, the corridor results in lower ceilings while for only 7 is there a higher ceiling. The 13 groups with lower ceilings include three with a reduction of more than 10%. There are no groups with 10% increases in their ceilings.

Thus, it seems obvious that the ceiling methodology of §86.13(c) cannot be considered rational and equitable but is in fact a method for further reducing reimbursement below reasonable cost by the use of statistical distortions. The effect of 86.13(c) when coupled with 86.14(b) is to make even more unlikely a true determination of a hospital's reasonable costs. The use of a statistical method which is so aberrant in itself can only be a further attempt by the State to secure a preordained result, rather than to arrive at an equitable method of determining reasonable costs.

SECTION 86.21(k)

While the provisions of Section 86.21(k) do not have as immediate an impact upon 1976 hospital operations as the sections I have just discussed, they do, in our view, have an extremely serious long-range effect on hospital reasonable cost reimbursement.

As you are aware, hospital reimbursement under the New York State prospective reimbursement system in the approved State Plan is based upon the determination of allowable costs in a base year, and the trending forward of such costs for two years by assumed inflation factors in order to establish the rate to be paid for services in the rate year. Allowable costs in the base year under the approved plan are the actual costs of the hospital subject to certain limitations and disallowances spelled out in the

approved Plan methodology.

Section 86.21(k) radically changes the determination of allowable costs in a base year. Instead of the actual costs described above, the base year cost used to project rate year reimbursement is, under this section, the lesser of such actual costs or an artificial amount calculated by taking allowable costs for the immediately preceding year and trending them forward to the base year by means of the Department of Health's inflation factor. While this principle is established for the first time for base year 1976, the regulation establishes an endless chain in which actual costs and actual inflation factors become immaterial and the Health Department's guess as to the appropriate inflation factor, regardless of its accuracy, becomes all controlling.

To fully evaluate the impact of Section 86.21(k), it is also important to recognize the past performance of the State Health Department in establishing inflation factors. As the purchaser, it would seem unlikely to expect the Department to over-estimate inflation -- in fact experience shows consistent under-estimation in recent years, not only on occasion but as a rule. A brief history illustrates this.

In establishing indices for 1973, 1974 and 1975, the State Health Department established levels which had to be increased subsequently, either as the result of Court action

or following strong assertions by HANYS as to such inadequacies and subsequent rate review based upon actual experience. Such subsequent rate reviews, which took place both in 1974 and 1975, would no longer be possible under the appeals procedures proposed to you by the Department. Despite its record of under-estimating inflation factors, the Department now proposes to base the entire determination of base year allowable costs upon its inflation factors.

Even if the Department's estimate of the inflation factor should be correct, 86.21(k) would still prevent reasonable cost reimbursement. The ceiling imposed by this section is based solely on the rate of inflation and makes no allowance for cost increases due to expansion of facilities, changes in technology or patient mix.

Moreover, the provisions of 86.21(k) eliminate the possibility of having incentives for efficiency and economy, as is required in alternate methods of reimbursement like New York's. Efforts to reduce costs falling short of full success (perhaps because of inaccurate estimates of indices) result in penalties; yet there are no benefits to a hospital if its cost reduction programs are successful.

During November, 1975, HANYS contacted a select group of its members to evaluate with them what the impact of

Section 86.21(k) would have been had it been in effect for the fiscal year ending in 1973. Five of the sample hospitals were located in Brooklyn and five in the area of Broome County in upstate New York. While it was impossible to identify the separate effect of this provision on Blue Cross and Medicaid reimbursement and upon in-patient and out-patient revenues, the total revenue loss for the five Brooklyn hospitals for these programs would have aggregated over \$6,000,000 and the five upstate hospitals would have suffered a loss of over \$600,000. A copy of the result of these studies is delivered to you as Exhibit VI to our statement.

Exhibit VII to our statement shows a projection of how Section 86.21(k) would function on an in-patient basis over a projected four-year period. It assumes an annual 8% inflation factor and normal variations in inpatient days, with actual inflation factors varying from projected factors and similar normal changes. At the end of a four-year period, the impact of Section 86.21(k) would be a short fall of more than \$18.00 per patient day, or 10% of the total reimbursement. This would either have to be made up from other programs or by a proportional reduction in patient services. It is clear that there can be no reasonable cost reimbursement under the 86.21(k) methodology.

SECTION 86.26

The third regulation which was discussed in our argument before Judge Lasker was the provision in Section 86.26 disallowing, on an across-the-board basis, 10% of the cost of salaries and fringe benefits for interns and residents. In our view, the State did not even follow the necessary procedural and substantive State law requirements when it promulgated this regulation. The procedural history of this section started when it was submitted this year as proposed legislation to the New York State Legislature, which then rejected it. There appears to be some dispute as to the basis for the Legislature's failure to pass this proposal. Senator Lombardi, Chairman of the State Senate Health Committee, has expressed the view that the provision was rejected on substantive grounds. I am submitting as Exhibit VIII Senator Lombardi's comments on this subject. The State Health Department maintains, however, that the Legislature's failure to act was based upon its decision that the legislation was superfluous. Regardless, the Health Department then twice proposed to the State Health Review and Planning Council, the agency charged with the adoption of rules and regulations under Part 86, that such a limitation be placed in Part 86. On both occasions the Council also rejected the proposal.

Finally, the Commissioner promulgated the proposal under his interpretation that he had the inherent power to do so. His promulgation was done without the required statutory notice to the Legislative leaders, on the alleged ground that \$86.26 represented an emergency regulation for the preservation of the public health and welfare.

On the substantive side, the section purports to implement state law (Public Health Law Section 2807.3) which provides for the exclusion by the Commissioner of "those parts of the costs for educational salaries...not directly related to hospital service." (Emphasis supplied). It does this simply by finding that the 10% disallowance represents the exclusion of educational activities not directly related to patient services. It should be noted that the definition of "hospital service" in Section 2801.4(a) of the same law includes "service provided by an intern or resident in training."

The major issue before you for determination by HEW is, of course, the impact of this provision upon a determination of reasonable cost. Until January 1, 1976, and, under this specific regulation after March 31, 1977, all of the salary costs of interns and residents are part of the reasonable cost of in-patient hospital service. It is only during this fifteen month period that a different rule is to apply. In fact, however, salary and fringe benefit costs for interns and residents have consistently

been allowed by all major government and private third party payers. Interns and residents work long hours and perform direct services to care for patients. The affidavit of Dr. Pomrinse, Executive Vice President of Mount Sinai Hospital, submitted to Judge Lasker, which is part of our Exhibit I, indicates that the hours of interns and residents at Mt. Sinai Hospital in New York approximate eighty hours per week. The services which they perform would have to be provided by other employees at greater expense, if they were not part of the responsibilities of the interns and residents at the institution. In fact, studies have indicated that it would cost substantially more to provide these services through full-time employed physicians than it does through interns and residents as at present.

The very nature of the educational process negates the theory that a portion of the salaries paid to interns and residents are for education. Except in unusual circumstances, involving a limited number of students on fellowships, students are not paid for education -- they pay for it. That payment is provided by interns and residents when they care for patients. This care is the quid pro quo for the post-graduate medical training they receive working in a teaching setting. The payment received by interns and residents of modest amounts is in recognition of their contribution to patient care. It is hardly a form of

scholarship to pay these graduate physicians to continue their education. It is difficult for me to make more convincing arguments as to the absurdity of this provision than have been made by Dr. Pomrinse in his affidavit which is before you.

Similar facts are set forth in the affidavit of Mr. Darrell Hartline of Genese Hospital in Rochester, New York, also contained in Exhibit I.

Further proof of the fact that the determination contained in Section 86.26 has no relevance to the reasonable cost of providing hospital service, and that it is based purely upon budgetary considerations, is the fact that it was consistently rejected by the Council and was adopted by the Commissioner of Health only after the Director of the Budget had refused to approve rates unless such a provision were adopted.

There is a further irony regarding the adoption of this restriction upon reimbursement. There is no way in which a hospital can avoid the impact of this provision through cost reductions. If the hospital reduces the number of its interns by 10%, it still is allowed only 90% of the remaining costs. If it reduces salaries and fringe benefits by 10%, it is reimbursed for only 90% of what it then pays. Thus there is no way in which a hospital, whose

only source of revenue is from patient fees and charity, can cover the cost of these important workers in the provision of hospital services and patient care.

* * *

Three of the proposed changes in Part 86 not only impose penalties and result in arbitrary reductions of reimbursement, but represent a blatant denial of due process.

SECTION 86.17(g)
SECTION 86.17(f)

Section 86.17(g) imposes a 10% reduction in reimbursement for an institution found to be providing an otherwise undefined "unacceptable level of care." This penalty is implemented without any notice or hearing. Let it be clear that we do not defend the provision of unacceptable levels of care; but any such finding must first be fairly demonstrated. We have already had experience with the use of this section. Without notice to the hospital, the Commissioner of Health on June 17, 1976, proposed to the State Hospital Review and Planning Council, which then found, that three hospitals (one of which is a non-profit voluntary hospital) were providing "an unacceptable level of care". The rates of these hospitals were then ordered reduced by 10%. On August 5 three more hospitals were subjected to reduced rates without notice under the same procedure.

On July 7, after the first 3 penalties were imposed, HANYS called to the attention of the State Health Department various ways in which it felt that due process had not been followed, including the absence of notice and hearing, and the fact that there appeared to be errors even in the minimal information upon which the State Health Department had urged the Council to act. The State's response dismissed these due process arguments with such comments as "The question of 'an unacceptable level of care' would not have developed as an issue if in the first instance the facility corrected the deficiencies * * * It seems to me that if anyone was unfairly treated it was the patients rather than the hospital * * * Any facility which has not corrected deficiencies [otherwise undefined] may assume that such failure would be brought to the attention of the * * * Council for determination of the level of care being provided."

It is interesting to note that among the allegations of unacceptable level of care with respect to the voluntary non-profit hospital was insufficient equipment in the Radiology Department for handling the demands of patients, and inadequate space in the Emergency Department. The reduction in reimbursement will certainly not make possible a resolution of these problems. Most remarkable is the

allegation that the hospital was not performing PAP smears on female patients over the age of twenty-one, since the hospital has in its possession a letter from the same Department of Health signed by the Director of the Cancer Control Bureau referring to its 100% compliance rate with the PAP testing program and congratulating it as being a pace setter with respect to the provision of this service. Although HANYS called this to the attention of the State Health Department, the Department nevertheless reiterated, without documentation, that there was a PAP smear deficiency. Whatever may be the merits of particular facts as to the institution, the establishment of minimal standards of due process, including notice and hearings, would avoid those conflicts of fact and meet basic requirements of fairness.

It is further worthy of note that the sum total of consideration by the State Health Review and Planning Council of the Commissioner's recommendation for this 10% reduction in rates was approval of a motion that the rate be reduced without any discussion. And there has already been a further impact from this action taken without due process under an unapproved regulation. The State informed the Medicare intermediary of its finding of an unacceptable level of care. On July 13, the intermediary rejected an application by the hospital to participate in the Medicare PIP program based

upon this finding - thus prejudicing the hospital's rights under Medicare with which the State has no relationship. I would like to submit for the record as our Exhibit IX the transcript of the Health Review and Planning Council dealing with this matter, the alleged findings with respect to this hospital presented to the Council, the letter from the Director of the Cancer Control Bureau to which I referred, the letter denying the hospital participation in the PIP program and the exchange of correspondence regarding due process between the HANYS and the Department of Health.

The impact of the determination under Section 86.17(g) that a hospital is providing an unacceptable level of care does not, however, end with the imposition of the 10% penalty. Under Section 86.17(f), which is also before you, the Commissioner may refuse to accept or consider any appeals, including those having nothing to do with the level of care penalty, from a hospital which is found to be providing an unacceptable level of care. Thus, this finding, made without notice or hearing, not only reduces reimbursement but precludes appeals which may seek sufficient rate adjustments in order to permit the correction of the alleged inadequacies. Lest you think that I am creating an unrealistic, hypothetical situation, let me assure you that we are advised that this has actually been the case in at least one application by

an upstate hospital under prior proposed versions of these regulations.

SECTION 86.8(f), SECTION 86.31,
SECTION 86.8(d)

Section 86.8(f) would impose 7% annual interest on all overpayments to hospitals and authorize the Commissioner of Health to impose further penalties on a hospital: (1) in an amount up to 25% of an overpayment for negligent incorrect completion of fiscal and statistical reports or negligent failure to file revisions of such reports and (2) in an amount up to 100% of an overpayment for wilful incorrect completion of such reports or wilful failure to file revisions thereto.

No due process safeguards are provided prior to the imposition of a penalty under this section. There are no notice requirements, hearing or other opportunities for a hospital to submit evidence to the Commissioner. Furthermore, the amount of the penalty authorized for simple mistakes by a hospital in its financial reports is clearly excessive and in violation of due process which requires "that the punishment follow rationally from the facts." Cross v. United States, 512 F.2d 1212, 1217 (4th Cir. 1975). Given the inexact nature of the fiscal and statistical filing requirements adopted by the Health Department, there must

of necessity be many situations in which final audits may determine that overpayments have been made. These are not the kind of situations, however, where it is equitable to impose the severe economic sanctions authorized by this section. This is recognized in the Medicare program which has no penalties for incorrect or insufficient submission of provider data.

The complete inequity of this section is apparent from the fact that it provides for the imposition of interest on overpayments to the hospital but no similar interest against the state for underpayment, should this be disclosed by audit or any other reason. Such underpayments, it should be noted, are not uncommon. Such discrimination is hardly consonant with the requirement that hospitals be reimbursed their reasonable costs.

Further compounding the inequity of this section is the absence of any definition of "incorrect completion" or of the reports or revisions which hospitals are required to file. These appear to be matters left solely to the unfettered discretion of the Commissioner. If hospitals are to be subject to penalties for failure to submit specific reports and documents, these should be clearly identified.

When this section is viewed in conjunction with

86.8(d) it becomes clear that the Commissioner can unilaterally determine that a hospital owes the state money without providing the hospital with any effective opportunity to contest this finding. He can then, again without affording the hospital any opportunity to contest his determination, unilaterally impose interest and other penalties on the hospital.

When 86.8(f) is coupled with requirements such as those now contained in new Section 86.31, the impact of this provision both in denying due process and precluding the determination of reasonable cost becomes even more apparent. In fact, it becomes a classic example of Catch 22. Section 86.31 provides that the State must be notified immediately if any previously offered service is deleted and informed of the cost impact of such action. It states that any overpayment by reason of such deletion shall be subject to the interest and penalties provided for in Section 86.8(f) which I have just discussed. Thus, by virtue of the ceilings in 86.14(b), the State is, in effect, mandating reductions of services which under Section 86.31 then further reduce reimbursement. Such reduction in reimbursement is then subject to the interest and penalty of 86.8(f). Despite the fact that 86.31 has not yet been approved by HEW, the State of New York has already applied it to at least one hospital with the result of depriving

that hospital of over \$1 million in reimbursement. Needless to say, the hospital was not provided with any opportunity to contest this at any form of administrative hearing.

Section 86.8(d) makes Section 86.8(f) even more onerous. It would set a 30 day limit from the date of mailing of audit findings for a hospital to appeal these findings. Within this 30 day period, the hospital must submit all of its data in opposition to the challenged findings unless an extension of time is granted by the Health Commissioner.

If, within the 30 day period, the hospital does not submit complete data which the Health Department finds to be a sufficient response to its audit, the hospital is deemed to have accepted the audit findings and therefore to be subject under 86.8(f) to the interest and penalties on overpayments. However, there is nothing in Part 86 which tells a hospital the amount or nature of the information necessary to complete an appeal of an audit finding. There is also nothing in Part 86 specifying the circumstances under which the Commissioner will grant an extension to file additional data. Most important, however, there is no provision for a hearing on a hospital's claim that an audit finding over overpayment is incorrect. The failure to provide such a hearing has been specifically found to violate due process standards.

In White Plains Nursing Home v. Whalen, CCH Medicare and Medicaid Guide ¶27,890 (New York Supreme Court, Appellate Division, 3d Department, July 1, 1976) the court found that a determination of overpayment of a Medicaid reimbursement rate could not be unilaterally made by the Health Commissioner, but that notice and a hearing was required:

"The petitioner undertook to perform its nursing services in reliance upon the said [Medicaid reimbursement] rate and has received the money. Under such circumstances, we must conclude that petitioner has a property right in the alleged overpayments. 'Where the exercise of a statutory power adversely affects property rights - as it does in the present case - the courts have implied the requirement of notice and hearing, where the statute was silent' (Matter of Hecht v. Monaghan, 307 N.Y. 461, 468). The petitioner herein is entitled to a due process hearing on the challenges brought by appellant to its rights to keep monies already paid (Matter of Birnbaum v. Whalen, - Misc. 2d -, 380 NYS 2d 590; See, also, Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp. 646).

We also conclude that a hearing, not limited to the question of the recoupment of past payments, is warranted in this case to create an adequate record for review." CCH Medicare, Medicaid Guide at 9656. Emphasis in original.

In Birnbaum v. Whalen, 380 NYS 2d 590 (Supreme Court Monroe Co., February 13, 1976), cited by the court in White Plains Nursing Home, supra, a retroactive downward adjustment of a Medicaid reimbursement rate on the basis of New York State Health Department audits was found to violate due process

because the provider was denied a hearing on the question of the audit findings.

It is significant that, in contrast to the system proposed by the State of New York Medicare allows providers an opportunity to contest audit findings at a hearing (20 CFR §§405.1801-405.1890).

SECTION 86.17

Added to the impact of all of the foregoing sections are serious shortcomings in the entire appeals procedure contained in Section 86.17. When the State Plan was first promulgated, it was the appeals process which provided the means by which reasonable cost was to be achieved despite the uncertainties and inexactness of the prospective reimbursement system.

Section 86.17(a) limits the grounds upon which a hospital can appeal its Medicaid reimbursement rate to seven narrow areas which are much more restrictive than those allowed under the comparable provision in the approved State Plan. Inasmuch as the New York State prospective rate setting system makes no provision for end-of-the year adjustments, it is important that it be as

flexible as possible and recognize unforeseen and special circumstances. The State cannot seriously claim that it can predict a year in advance, with absolute accuracy, all of the factors that will affect a hospital's operations. It was to take these considerations into account that the original appeal mechanism was developed, and that it was approved by HEW.

Under the existing appeal mechanism which the State seeks to change, appeals have been allowed from grouping determinations and from rates which did not take account of cost increases resulting from subsequently mandated labor arbitration awards and governmental action such as increased unemployment insurance taxes. None of these appeals would be allowed under the proposed amendment to the State Plan, which would also eliminate the possibility of appeals based on the incorrect application of the rate setting methodology to a particular hospital and perhaps even such major unprojected cost increases as the calamitous rise in premiums for malpractice insurance.

But even appeals which appear to be permitted by the language of the section are, in fact, rejected by the Department. For example, discussion was held with the Department directed at increased reimbursement for an expensive

utilization review program mandated by the Department of Health. Such appeals appear to be provided for in Section 86.17(a)(3). Nevertheless, the Department advised that it would not consider such appeals on economic grounds. Similarly, the Department has apparently refused to consider appeals on numerous other grounds not contemplated by provisions of Section 86.17. It has rejected appeals by an individual hospital because there was allegedly a group of hospitals pursuing a similar appeal, although the hospital had disassociated itself from the group. It has even refused to accept appeals on the ground that a hospital was litigating with the Department on some other issue. Submitted herewith as Exhibit X, are copies of Departmental letters documenting each of these situations.

The claim of the Department that its proposed appeal procedure would counteract the failings of the ceiling provisions of Section 86.14(b) is particularly unbelievable under these circumstances. When the period for pursuing an appeal is between four and nine months and has, on occasion, involved a period of years, and when the Department has expressed the view that reimbursement matters should be resolved on an industry-wide basis and that the "Medicaid appeal processes [are] already intolerable" (see Exhibit X) it is difficult to give credence to the claim that a system

which would require appeals from more than 60% of all hospitals will result in the payment of reasonable costs within a reasonable time. Even if such an appeals procedure has now been filed (of which we are not aware), the argument cannot stand on the merits. The State's own intentions in this respect are clear -- Senior State officials advised State Senate Health Committee Chairman Lombardi at a meeting, the transcript of which has been presented to you as Exhibit VIII, that relief under such appeals would be granted to not more than twelve or thirteen hospitals. Similar statements have been made on other occasions at which the ceilings were discussed with State officials.

The necessity of having a flexible appeal mechanism in a rate-setting system is recognized by Medicare which allows providers to appeal reimbursement on broad nonspecific grounds. This approach, unlike that proposed by the State, is consistent with fundamental substantive due process under which a state may not deprive a citizen of property without benefit of a hearing. North Georgia Furnishing, Inc. v. Di-Chem, Inc., 419 U.S. 601 (1975); Mitchell v. W.T. Grant Co., 416 U.S. 600 (1974) and Fuentes v. Shevin, 407 U.S. 67 (1972).

In order to fully appreciate the burden which this

new appeal mechanism places upon the hospitals, it is necessary to understand the manner in which the Health Commissioner actually processes hospital appeals. There are no procedural guidelines set forth defining the steps which will be followed in the handling of a hospital's appeal. There are no time limits, specific hearing procedures, or notice requirements. In contrast, the Medicare program has a detailed set of regulations and guidelines dealing with these issues.

A hospital which desires to take an appeal sends a letter to the Department of Health setting forth the grounds that it believes justifies the granting of an appeal. If the hospital is persistent enough, an informal conference will eventually be set up between its representatives and those of the Health Department. At this conference the hospital will explain to the Health Department personnel why it believes an appeal is justified. No stenographic record is made of this conference. At some future time the hospital will be notified by letter of the Health Commissioner's decision. This notification frequently gives no explanation for the decision reached.

For the past several years the hospital industry in New York State through HANYS has proposed that the State modify its existing appeal system to bring it into conformity

with fundamental due process requirements. In line with this approach, HANYS submitted an actual draft of an appeal process to the New York State Health Department in 1973. Unfortunately, the Health Department was completely unreceptive to these attempts to work with them in developing a system which was both responsive to the needs of the hospitals, the resources of the State and fundamental principles of due process.

OTHER PROVISIONS OF PART 86

In addition to the seven key sections which we have already discussed, we wish to call to your attention certain additional proposed amendments to the State Plan which we believe should not be approved by HEW. They also prevent the determination of a rate representing the reasonable cost of the provision of in-patient hospital services, and they similarly raise serious questions of due process. It is only because of the overwhelming impact of the sections that I have already discussed that these sections take a lesser position in our testimony.

Section 86.9(e) contains specific limits on reimbursement where less than a specified number of certain procedures are performed by an institution. Where less than 100 open heart surgical procedures, less than 200 other cardiac invasive

procedures and less than 25 kidney transplants are performed by an institution during the course of a year, the institution's reimbursement is reduced by a mathematical formula which in effect assumes the same cost has been incurred but that there had been performed the minimum of 100, 200 or 25 procedures respectively. No justification has been established for these particular criteria, and while we are sympathetic to the need to centralize certain major surgical activities, we believe this is a matter for administrative regulation rather than for reimbursement penalties. In fact, the necessary result of the imposition of these penalties is to reduce reimbursement below reasonable costs.

An example of the impact of these provisions has recently come to our attention. A small hospital showed on its statistical report that it had performed one open heart surgical procedure during the course of the year, perhaps due to the admission of an emergency patient with heart injuries. Under the proposed regulation, if the average stay for open heart surgery is 20 days, the institution would be penalized by having 1,980 days added to its patient day denominator in determining per diem reimbursement. The provisions for waiver of the penalties by the Commissioner give little comfort in this respect. First of all, there are no criteria

for this determination by the Commissioner. In addition, while similar waiver powers by the Commissioner exist with respect to the present minimum occupancy levels of 60%, 70% and 80% established under Section 86.9(d) of the regulations, recent actions by the Commissioner upon applications for waiver of those penalties give reason to believe that such waivers will be granted infrequently. The fact that there are no distinctions between emergency procedures and unsanctioned non-emergency surgery; the fact that the same standards are applied to hospitals located in center cities, urban areas and rural communities; and the fact that there has been no justification for the specific number of procedures selected is strong argument for disapproval of this section. It should be noted that Part 86 also contains similar restrictions on reimbursement with respect to out-patient services involving the performance of less than 6,000 radiotherapy procedures and 1,200 renal dialysis procedures, and that these are similarly unsupported and unjustified.

Section 86.14(e) provides that hospitals operated by the New York City Health and Hospitals Corporation are to be identified with respect to type and size with the appropriate group of voluntary facilities developed under the general grouping criteria and are to be subject to ceilings established for such voluntary groups of facilities.

We have previously pointed out the inconsistency of the entire ceiling procedure both with respect to the 75%-125% corridor used to find the 100% ceiling, and then the application of the 100% ceiling itself. Nevertheless, while hospitals in the Health and Hospitals Corporation are excluded from the groups in which they are placed for purposes of defining what is the 100% amount, they are included for purposes of imposing the ceiling. The recently announced reduction in reimbursement for New York City Health and Hospitals Corporation institutions that apparently played a major role in the labor crisis affecting those hospitals is a direct result of the illogical placement of these institutions in groups to which they do not appear to belong, and the equally illogical application of ceilings to them when they are excluded from the ceiling calculations.

Section 86.15(b) excludes from trending for inflation certain major costs of a hospital's operation which are necessary components of the reasonable cost of providing hospital services. It eliminates from trending not only capital costs, realty leases and return on net equity capital but also equipment leases, equipment depreciation and interest related to equipment purchases and other short-term needs. Unlike real property, equipment is subject to rapid technological

obsolescence, and there are annual changes in equipment needs and in the amount charged by equipment lessors in the marketplace. Even if ownership cost of equipment purchased for long-term use is not to be trended, short-term equipment lease costs attributable to the rental of such equipment as computers under true leases rather than lease purchase contracts should be trended to reflect the actual conditions in the marketplace.

Although Section 86.15 refers to realty leases and leases related to equipment, and by implication implies that such costs are allowable, Section 86.30 states that "[t]he capital cost of a facility . . . shall be determined and computed in accordance with the provisions of sections 86.23, 86.24, 86.29 of this Part" Section 86.23 refers to depreciation expense, Section 86.24 refers to interest expense and Section 86.29 refers to return on investment for proprietary hospitals. Nowhere in Part 86 is there a specific indication that costs associated with realty leases or equipment leases are allowable costs.

Section 86.21(i) also limits reimbursement in a manner which effectively prevents the payment of reasonable cost. This section provides that allowable cost is not to include any interest charged or penalty imposed by governmental agencies

or courts. It may have been the intent of the State to cover only punitive interest. However, this provision excludes from reimbursement not only such major items as mortgage interest on government loans which finance much of hospital construction, but also other normal course of business interest which may be payable to governmental agencies. In addition, of course, this section would disallow the one-sided 7% interest charged to hospitals under Section 86.8(f), discussed earlier. This interest payment therefore assumes the nature of a penalty, even in the absence of any charge of negligence or wrongdoing.

RETROACTIVITY

The State has asked HEW to approve its proposed amendments to the State plan retroactively to January 1, 1976. Any such retroactive approval would result in serious injury to hospitals in New York State inasmuch as the new regulations drastically reduce hospital reimbursement below levels required under the approved State Plan and anticipated at the time services were rendered Medicaid patients. In the case of approximately one-third of the hospitals, the proposed regulations produce rates below 1975 levels. Since the hospitals were paid at 1975 rates for the first 6 months of 1976, this group of hospitals will be placed in the position of having

to repay the difference between these new rates and the 1975 rates to the State. This is money which many of these hospitals do not have. If the State is permitted to reclaim these funds, hospitals will have no choice but to cut back on health services. The ultimate losers will be the people of this State.

Retroactive approval of the proposed amendments would violate the Medicaid Act and regulations and fundamental principles of due process. The Medicaid Act, (42 USC §1396a(a)(13)(D)), and regulations, (45 CFR §250.30(a)(2)), specifically require the Secretary's pre-implementation approval of any change in the methods and standards for calculating the reasonable cost of inpatient hospital services. The specific statutory language states that any such method or standard shall be included in the plan "after notice of approval by the Secretary" while the relevant regulation provides that any new method or standard shall be "approved in advance of implementation". Any retroactive implementation of the proposed amendments to the plan would have the obvious effect of nullifying these two provisions.

In addition to being a violation of the Medicaid Act and regulations, retroactive application of the proposed State plan amendments would constitute a serious violation of the

hospitals' due process rights. Under Federal law, participation by a provider in the Medicaid program is voluntary. In good faith, hospitals have been participating in the program and have rendered services to Medicaid patients expecting to receive payment on the basis of the methodology in the approved State plan at the time services were rendered. It would be unconscionable to change the terms of payment for these services when the hospitals no longer have the option of deciding whether or not to participate in the program.

The relationship between the State of New York and the hospitals with respect to the provision of Medicaid services is that of an implied contract. In a contractual relationship such as this, neither party can unilaterally change the terms and conditions of the contract. However, that is exactly what the State is attempting to do in this situation.

A number of recent federal court decisions have considered this question. Most directly on point is Columbia Heights Nursing Home and Hospital, Inc. v. Weinberger, 380 F. Supp. 1066 (D.C.N.D. La., 1974) in which the court refused to allow a Medicare intermediary to retroactively change its auditing procedures after final audit and payment for the rate years in question. The retroactive application would have resulted in a finding that an overpayment had been made

to the provider. This, the court felt, "would be grossly unfair, terribly unjust, and not justified by a fair reading of the statute and regulation involved" 380 F. Supp. at 1072. The court explained

"Neither the Act nor the regulation contemplated or permits the rules to be changed after the game has been played.

As was said in N.L.R.B. v. Majestic Weaving Co., 355 F.2d 854, 860 (C.A.2 -- 1966):

'Although courts have not generally balked at allowing administrative agencies to apply a rule newly fashioned in an adjudicative proceeding to past conduct, a decision branding as "unfair" conduct stamped "fair" at the time a party acted, raises judicial hackles considerably more than a determination that merely brings within the agency's jurisdiction an employer previously left without

* * *

And the hackles bristle still more when financial penalty is assessed for action that might well have been avoided if the agency's changed disposition had been earlier made known, or might even have been taken in express reliance on the standard previously established.'

There is no doubt but that the reporting procedure followed by Columbia Heights prior to 1973 was a procedure followed in express reliance on the standards previously established by the Secretary of Health, Education and Welfare through his intermediaries and agents...."
Id.

A similar result was reached in Coe v. Secretary of Health, Education and Welfare, 502 F.2d 1337 (4th Cir. 1974), in which the Court of Appeals refused to allow the retroactive application of a Medicare regulation which would have resulted in the denial of Medicare benefits to a Medicare patient's estate. The rationale for the court's decision was that

"[a]pplication of the current regulations in this instance constitutes a prohibited interference with Mrs. Coe's antecedent right to reimbursement at the time the services were rendered. Cf. Greene v. United States, 376 U.S. 149, 160 84 S. Ct. 615, 11 L.Ed.2d 576 (1964)." Id. at 1340

AN OVERVIEW OF THE NEW YORK STATE MEDICAID PLAN

When major proposals to revise the State Medicaid Plan are to be considered, as must now be done by HEW, it does not seem appropriate to consider them only singly and in the abstract. Rather, they should be examined in light of their interaction with the rest of the State Plan as presently applied, and the philosophy of prospective reasonable cost reimbursement.

We believe we have demonstrated the enormous adverse impact of the specific amendments now under consideration. That impact becomes even greater when considered in conjunction with recent rigid enforcement and denial of waivers of the

60-70-80% occupancy sanctions, use of questionable grouping criteria, imposition of limitations on applicable cost but consistent with Medicare proposals and other similar changes. One is led to the inescapable conclusion that the overall impact of the State Medicaid Plan as it is now proposed is so substantially different from that originally approved by HEW that de novo consideration should be given to whether it complies with the reasonable cost requirements and other approval criteria under the Medicaid law and regulations.

The State Plan originated as a new prospective reimbursement system, tied to a liberal system for the correction of unintended and unanticipated damage, established in a climate of flexibility, and containing incentives for efficient production and improvements in the quality of hospital services. It has, unfortunately, developed into a rigid system which provides few, if any, possibilities for relief, is without incentives, and inevitably requires a continual reduction in the level of hospital services among the best institutions in the system.

We believe that, in addition to its review of the specific amendments now before it, HEW should again review the overall appropriateness of New York State's alternate method as now proposed and implemented, to determine whether it still complies with the letter and spirit of the Medicaid Program.

CONCLUSION

In conclusion, it is the sincere belief of the representatives of the non-profit voluntary and public hospitals of New York State that the proposed amendments to the State Plan and their implementation would seriously injure the ability of these hospitals to provide quality medical care not only to eligible Medicaid recipients but to the public as a whole. The principal cause is the fact that these regulations would not only fail to provide for the payment of the reasonable costs of in-patient hospital services as mandated by federal law, but would in fact prevent such payment. Again, let me reiterate the willingness of the hospital industry to try to work out with State officials reasonable means for dealing with the State's fiscal crisis within the limits of the law.

We believe that we have adequately demonstrated that these amendments to the State Plan should not be approved. We suggest that the broadest range of information would become available to HEW and the ends of full disclosure best served if hospital representatives have the opportunity to comment on any further State submittals made in response to your questions. We stand available to consult with you and others in the Department to that end.

EXHIBITS

- I. Litigation Papers
- II. Effect of Patient Mix on Per Diem Cost
- III. Effect of Patient Mix on Length of Stay
- IV. Sample Medicare Routine Cost Ceiling
- V. New York State Work Sheets for Ceiling Computation
 - A. Abstract as to Sample Group A
 - B. Abstract as to Sample Group B
- VI. HANYS Study of Section 86.21(k) Impact
- VII. Assumed Impact of Section 86.21(k) After Four Years
- VIII. Lombardi Task Force Meeting Minutes
- IX. Unity Hospital Documents
- X. Rejection of Appeal Documents

COVINGTON & BURLING

888 SIXTEENTH STREET, N. W.

WASHINGTON, D. C. 20006

TELEPHONE (202) 452-6000

WRITER'S DIRECT DIAL NUMBER

452-6290

September 8, 1977

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HOWARD C. WESTWOOD
JOHN T. SAPIENZA
JAMES H. MCGLOTHLIN
ERNEST W. JENNES
STANLEY L. TENKO
DON V. HARRIS, JR.
WILLIAM STANLEY, JR.
WEAVER W. DUNNAN
EDWIN M. ZIMMERMAN
JEROME ACKERMAN
HENRY P. SAUER
JOHN H. SCHAFER
ALFRED H. MOSES
JOHN LEMOYNE ELLICOTT
PAUL R. DUKE
PHILIP R. STANSBURY
CHARLES A. MILLER
RICHARD A. BRADY
ROBERT E. O'MALLEY
EUGENE I. LAMBERT
JOHN VANDERSTAR
NEWMAN T. HALVORSON, JR.
HARVEY M. APPLEBAUM
MICHAEL S. HORNE
JONATHAN D. BLAKE
CHARLES E. BUFFON
ROBERT N. SAYLER
E. EDWARD BRUCE
DAVID M. BROWN
PAUL J. TAGLIABUE
ANDREW W. SINGER
DAVID H. HICKMAN
RUSSELL H. CARPENTER, JR.
NICHOLAS W. FELS
THEODORE L. GARRETT

CHARLES A. HORSKY
W. CROSSBY ROPER, JR.
DANIEL M. GRIBBON
HARRY L. SHNIDERMAN
EDWIN S. COHEN
JAMES C. MCRAE
JOHN W. DOUGLAS
HAMILTON CAROTHERS
J. RANDOLPH WILSON
ROBERTS B. OWEN
EDGAR F. CZARRA, JR.
WILLIAM M. ALLEN
DAVID S. ISBELL
JOHN B. JONES, JR.
H. EDWARD DUNKELBERGER, JR.
BRUCE MCADDO CLAGETT
JOHN S. KOCH
PETER BARTON HUTT
HERBERT DYM
CYRIL V. SMITH, JR.
MARK A. WEISS
HARRIS WEINSTEIN
JOHN B. DENNISTON
PETER J. NICKLES
MICHAEL BOUDIN
BINGHAM S. LEVERICH
ALLAN J. TOPOL
VIRGINIA G. WATKIN
RICHARD D. COPAKEN
CHARLES LISTER
PETER D. TROGBOFF
WESLEY S. WILLIAMS, JR.
DORIS D. SLAZEK
WILLIAM D. IVERSON

NEWELL W. ELLISON
JOHN G. LAYLIN
H. THOMAS AUSTERN
FONTAINE C. BRADLEY
EDWARD BURLING, JR.
J. HARRY COVINGTON
COUNSEL
—
JOHN SHERMAN COOPER
OF COUNSEL

TWR: 710 852-0008
TELEX: 86-863
CABLE: COVUNG

The Honorable Morris E. Lasker
United States District Court
Southern District of New York
United States Court House
Foley Square
New York, New York 10007

Re: Hospital Association of New York
State, Inc., et al. v. Toia, et al.
(76 Civ. 2027 (MEL))

Dear Judge Lasker:

This responds to plaintiffs' Motion dated August 19, 1977, accompanied by Mr. Imberman's affidavit of that date, which seeks further revision of the order of this Court entered on August 15, 1977, reflecting its disposition of the jurisdiction issue.

The state defendants oppose the requested further revision of the order, which would add a paragraph stating that the order is not intended and should not be construed as prohibiting or hindering plaintiffs from pursuing any state court remedy, including an injunction against the recoupment of funds previously paid to plaintiffs, which recoupment is ordered in the preceding paragraph of the order.

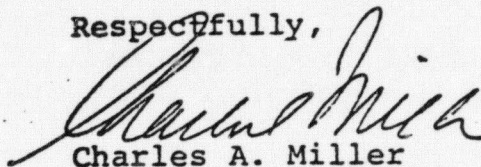
Mr. Imberman's affidavit (§ 2) says the additional provision is needed to preclude the state defendants from relying on this Court's recoupment order to defend against a state court action to enjoin the recoupment. This explanation is surely sufficient to defeat the request, for the state defendants do intend to rely on this Court's order in the event of a state court injunction proceeding and have every right to do so. Plaintiffs' Motion amounts to the remarkable request

The Honorable Morris E. Lasker
September 8, 1977
Page Two

that this Court in effect invite a state court to enjoin this Court's order of recoupment. Apart from the fact that this Court ought not be deciding what a state court can do if and when asked, the requested revision would make a mockery of this Court's carefully considered ruling on jurisdiction.

We respectfully urge that the requested additional revision of the Court's August 15 order be denied.

Respectfully,



Charles A. Miller
Attorney for the
State Defendants

mb

cc: Jacob Imberman, Esq.
Peter F. Nadel, Esq.
John M. O'Connor, Esq.

AFFIDAVIT OF SERVICE BY MAIL

STATE OF NEW YORK)
 : SS.:
COUNTY OF NEW YORK)

George M. Gundlach being duly sworn, deposes and
states:

I am not a party to the action, am over 18 years
of age and reside at W. End Ave. N.Y., N.Y.

On November 14, 1977 , I served the attached
Appendix
upon the following attorney(s) at the address designated
by ~~him~~ (them) for that purpose:

Peter Nadel, Esq.
Rosenman Colin Freund LEWIS & Cohen
575 Madison Ave.
N.Y., N.Y. 10022

Covington and Burling, Esqs.
888 Sixteenth St., N.W.
Washington, D.C. 20006

Alan Moller, Esq.
Assistant Attorney General
Two World Trade Center
N.Y., N.Y. 10048

John M. O'Connor, Esq.
United States Attorney's Office
1 St. Andrew's Plaza
N.Y., N.Y. 10007

Said service was made by depositing a true copy
of the attached

Appendix
enclosed in a postpaid properly addressed wrapper
in an official depository under
the exclusive care and custody of the United States Post
Office Department within the State of New York.

Sworn to before me this

14th day of November

1977.

Lynne E. Landsman

George M. Gundlach
George M. Gundlach
LYNNE E. LANDSMAN
NOTARY PUBLIC, State of New York
No. 31-465268
Qualified in New York County
Commission Expires March 30, 1979

